REINVENTING MICHIGAN'S HEALTH CARE SYSTEM
Blueprint for Health Innovation

Appendices
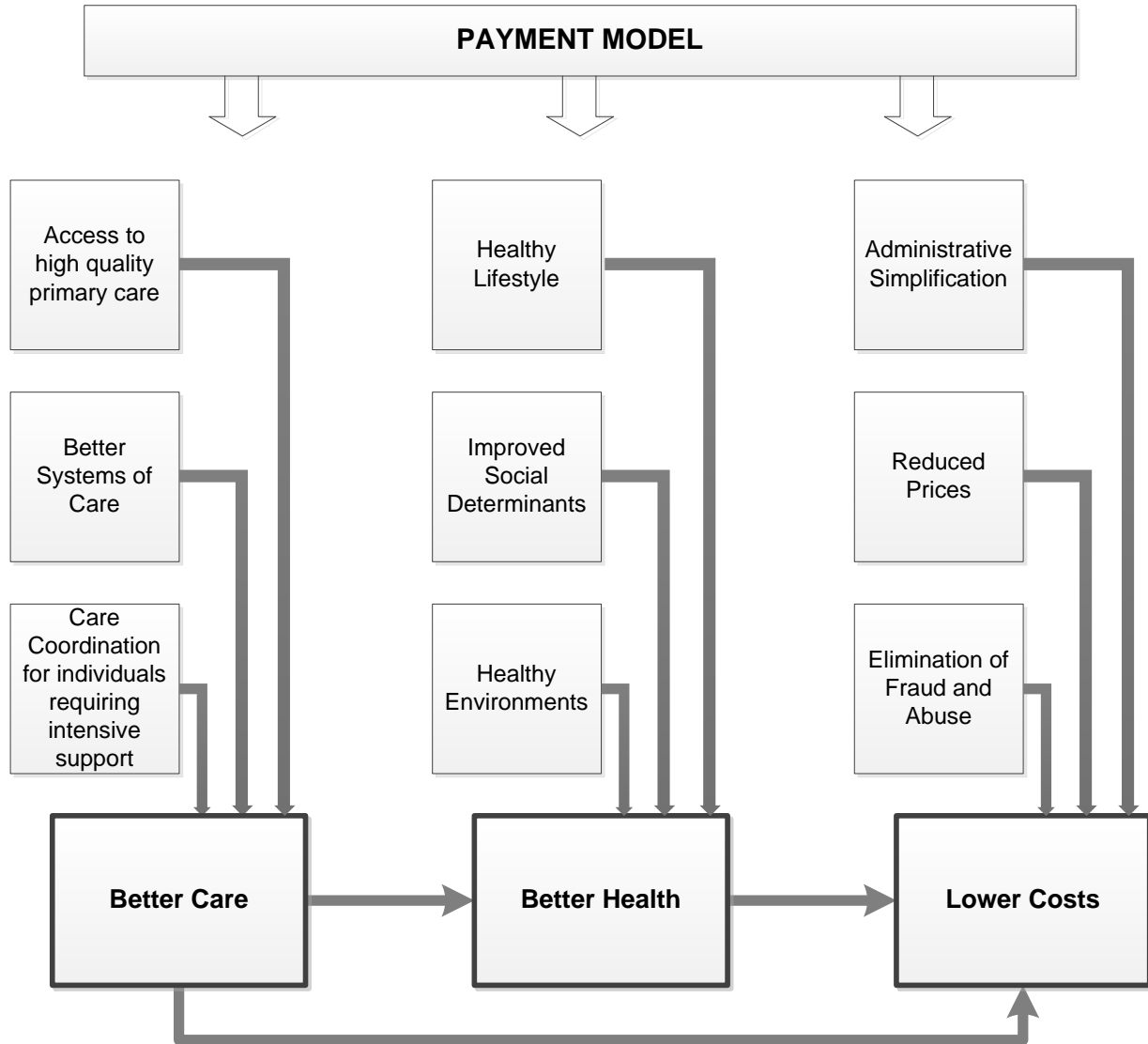
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Appendix 1.1: Michigan's Blueprint for Health Innovation Driver Diagram

PAYMENT MODEL

Access to high quality primary care

Better Systems of Care

Care Coordination for individuals requiring intensive support

Healthy Lifestyle

Improved Social Determinants

Healthy Environments

Administrative Simplification

Reduced Prices

Elimination of Fraud and Abuse
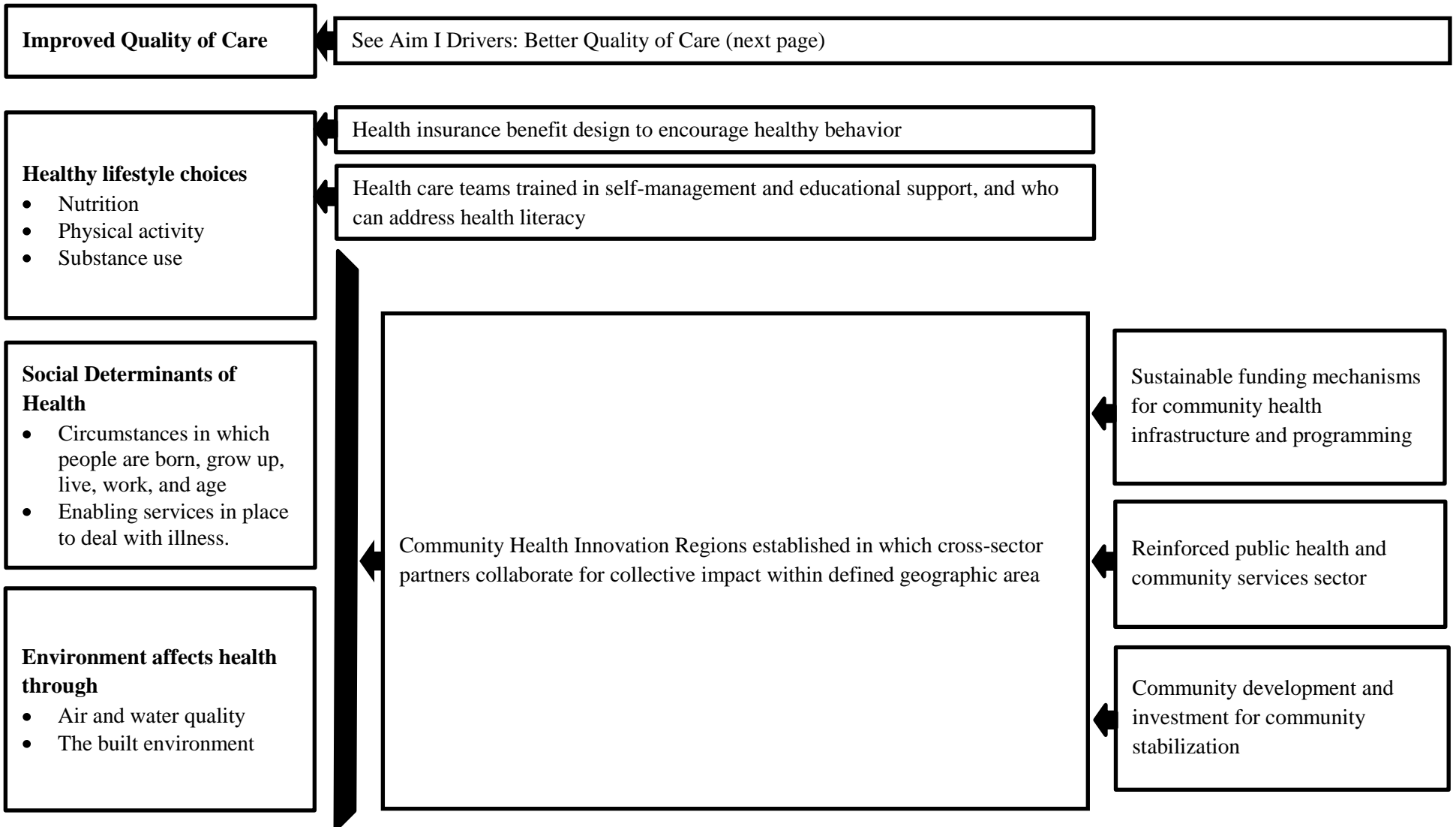
Better Care → **Better Health** → **Lower Costs**

How Michigan's Blueprint for Health Innovation Improves Population Health

Primary Drivers   **Secondary Drivers**   **Tertiary Drivers**

Improved Quality of Care	See Aim I Drivers: Better Quality of Care (next page)

Healthy lifestyle choices
- Nutrition
- Physical activity
- Substance use

Health insurance benefit design to encourage healthy behavior

Health care teams trained in self-management and educational support, and who can address health literacy

Social Determinants of Health
- Circumstances in which people are born, grow up, live, work, and age
- Enabling services in place to deal with illness.

Environment affects health through
- Air and water quality
- The built environment

Community Health Innovation Regions established in which cross-sector partners collaborate for collective impact within defined geographic area

Sustainable funding mechanisms for community health infrastructure and programming

Reinforced public health and community services sector

Community development and investment for community stabilization

How Michigan's Blueprint for Health Innovation Improves Quality of Care

Primary Drivers	Secondary Drivers

Strengthen primary care infrastructure to expand access for Michigan residents

- Expanded number of enhanced Patient Centered Medical Homes.

Payment models to reward value in care delivery:
- Payment for Care Management in Patient Centered Medical Homes
- Performance bonuses

Accountable Systems of Care that invest in Patient Centered Medical Homes for integrated systems of care across providers and settings of care.

Interprofessional team-based care with necessary linkages in order to address the medical, behavioral, and social care needs of the patient populations

Improve systems of care to ensure delivery of the right care, by the right provider, at the right time, and at the right place

- Promote clinical integration through Accountable Systems of Care

Central infrastructure to:
- Coordinate resources and support to implement the Blueprint for Health Innovation
- Convene and align multiple stakeholders to simplify administrative requirements
- Invest in health information exchange and multi-payer data
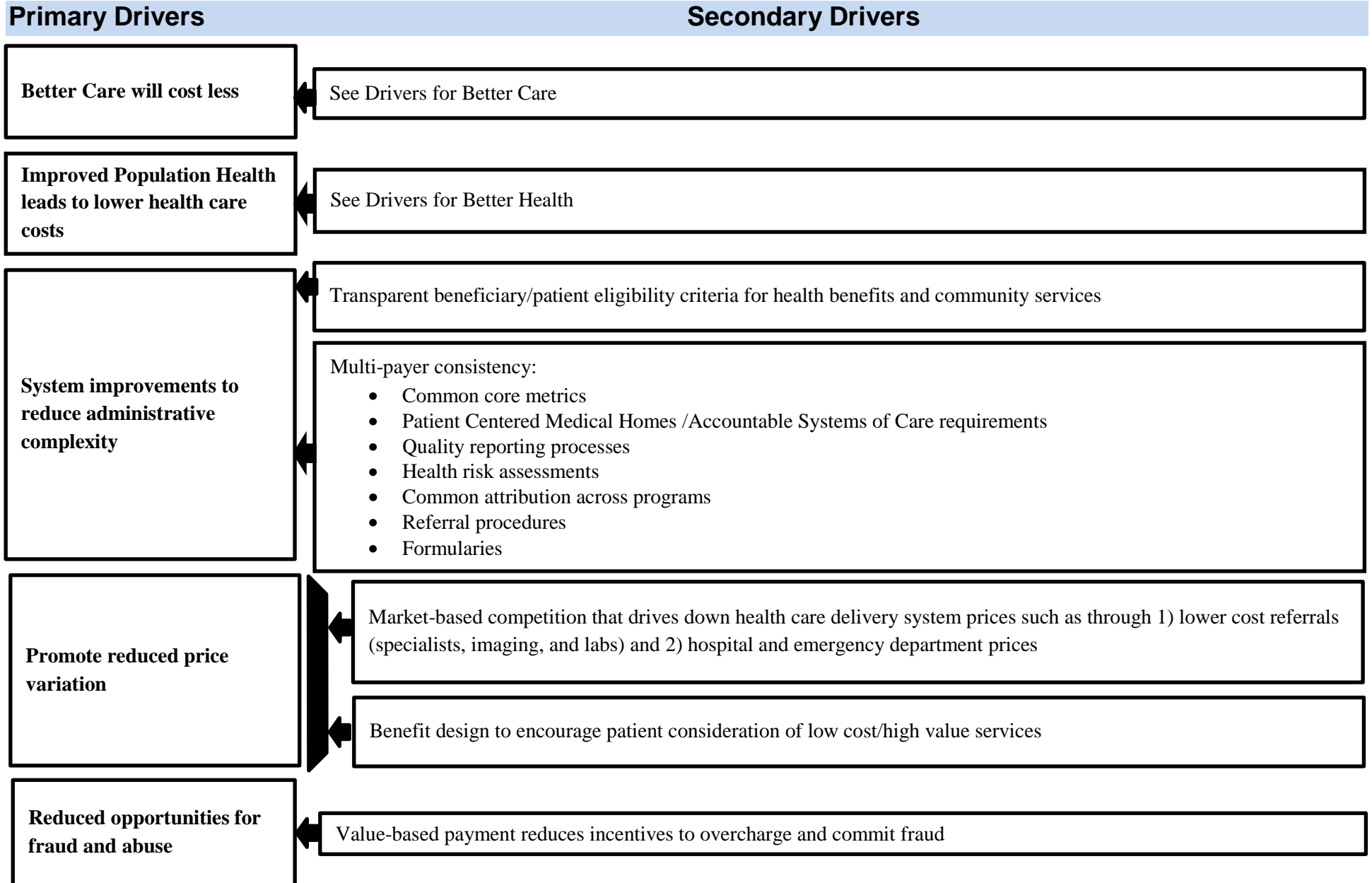
Community Health Innovation Regions in which partners
- Organize community services with clear entry points and navigation/supports coordination available for individuals requiring intensive support services
- Organize investments and activity around reduction of community health risks

Coordinated care to promote positive health and health care outcomes for individuals requiring intensive support services

Payment models reward care that provides the most value:
- Investment in infrastructure to develop clinical integration
- Targeted and high quality care to underserved and vulnerable populations
- Focus on child development, prevention, and retaining maximum functionality to remain in settings of choice

How Michigan's Blueprint for Health Innovation Contains Costs

Primary Drivers	**Secondary Drivers**

Better Care will cost less ← See Drivers for Better Care

Improved Population Health leads to lower health care costs ← See Drivers for Better Health

System improvements to reduce administrative complexity

← Transparent beneficiary/patient eligibility criteria for health benefits and community services

← Multi-payer consistency:
- Common core metrics
- Patient Centered Medical Homes /Accountable Systems of Care requirements
- Quality reporting processes
- Health risk assessments
- Common attribution across programs
- Referral procedures
- Formularies

Promote reduced price variation

← Market-based competition that drives down health care delivery system prices such as through 1) lower cost referrals (specialists, imaging, and labs) and 2) hospital and emergency department prices

← Benefit design to encourage patient consideration of low cost/high value services

Reduced opportunities for fraud and abuse ← Value-based payment reduces incentives to overcharge and commit fraud

Tertiary Drivers (underlie all Aims and Primary/Secondary Drivers)

The Policy and Planning Office will align programming across governmental units, coordinate policy and funding levers, and provide overall accountability for implementing and testing the Michigan State Innovation Model.

- Convenes a steering committee which monitors Michigan's Blueprint for Health Innovation performance data and adjusts the Blueprint as necessary through quality improvement processes
- Engages evaluation staff and/or contractor(s)
- Convenes multi-payer/stakeholder performance measurement and recognition committee to reduce variation across payers
  - Assures common measures and processes
  - Addresses issues related to certification/selection criteria (of Patient Centered Medical Homes, Accountable Systems of Care, Community Health Innovation Regions)
- Provides resources and support for health system transformation
  - Has learning system in place to track and improve progress towards the Blueprint for Health Innovation aims and conducts root cause analysis for quality improvement
  - Identifies areas of needed technical assistance for Accountable Systems of Care and Community Health Innovation Regions, and may provide investment in areas of highest need
  - Disseminates evaluation data and facilitates sharing of best practices
- Provides coordination with the following health information technology initiatives:
  - Michigan model for health information exchange
  - State of Michigan data hub
  - Medicaid Electronic Health Record Incentive Program and Regional Extension Center
- Acts as a liaison for Blueprint implementation with the following:
  - Medical Services Administration
  - Behavioral Health and Developmental Disabilities Administration
  - Public Health Administration
  - Office of the State Employer
  - Other State of Michigan departments for a health- in-all-policies approach
  - Centers for Medicare and Medicaid Innovation Center and other innovation funders
- Coordinates Certificate of Need, health planning and access to care efforts
- Health care workforce development/improvement

Performance measurement and recognition committee and framework for selecting and monitoring metrics and program requirements

- Convenes relevant stakeholders including payers, providers, and consumers to create and continually improve a standard set of core performance measures for a high-performance health system
- Monitors progress of the Blueprint for Health Innovation, updates metrics and program elements in response to input from stakeholders , evolving evidence from lessons learned
- Promotes confidence and trust in the metrics by which providers are measured

Core Data Infrastructure
- Health provider directory collects, tracks and updates provider affiliations
- Systems to collect, process, and disseminate outcomes data
    - Multi-payer
    - Claims and clinical data
    - Support aggregation at levels of provider, practice, Accountable Systems of Care, and population
    - Common data submission processes support multiple use
    - Subject to privacy and security requirements, data are available in appropriate formats for use by patients, providers, payers, researchers, and the State
- Health information exchange infrastructure supports electronic data sharing for patient health management, clinical care, and population management
- Transparent public reporting of outcomes

Appendix 2

Appendix 2.1: Current Federally-Supported Program Initiatives Under Way in the State

Michigan Pathways to Better Health

The Michigan Pathways to Better Health project is a three-year initiative funded by the Centers for Medicare & Medicaid Services through a Healthcare Innovations Grant. The goal of the project is to impact health care quality, cost, utilization, and health status by connecting clients to needed health and social services in order to improve their health, increase their utilization of primary care services, and decrease the cost of their health care through reductions. A local agency in each of the three participating counties is designated as a Pathways Community Hub. These Hubs identify and connect at-risk persons with chronic conditions to community health workers who work with the Hub's registered nurse and clinical social worker to coordinate access to health care services and human services (such as housing, nutrition, and transportation) that are needed to improve health. The Pathways Community Hubs provide necessary tools and strategies so that at-risk persons are served in a timely and coordinated manner, thereby avoiding duplication of effort and keeping persons on track in improving their health.

Michigan Health Information Network Shared Services

The Michigan Department of Community Health received a Cooperative Agreement grant from the Office of the National Coordinator for Health Information Technology to continue funding of Michigan Health Information Network Shared Services to improve health care quality, cost, efficiency, and patient safety through electronic exchange of health information. Michigan Health Information Network Shared Services is a joint effort among the Michigan Department of Community Health, the Michigan Department of Technology, Management and Budget, and a broad group of stakeholders from across the State.

Michigan Quality Improvement Network

The Michigan Primary Care Association has established the Michigan Quality Improvement Network, a health centered controlled network for Michigan health centers, which provides the support infrastructure to health centers utilizing quality improvement and system redesign methodology to improve performance outcomes in quality of care delivery, patient experience, and cost containment. The Network utilizes the Michigan Primary Care Association's data repository to aggregate practice management, electronic health record, registry, and other data, which are translated into meaningful information that can be used by providers and quality improvement staff to drive improvements in the health centers.

Bundled Payment for Care Improvement Initiative

The Bundled Payment for Care Improvement Initiative, funded by the Centers for Medicare and Medicaid Services, includes several Michigan hospitals and health care centers as participants in various phases and models. Under the Bundled Payments for Care Improvement Initiative, organizations have entered into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality, more coordinated care at a lower cost to Medicare.

Medicare Accountable Care Organizations

Michigan has two Medicare Pioneer Accountable Care Organizations: the Genesys Physician Hospital Organization and the Michigan Pioneer Accountable Care Organization, which is affiliated with the Detroit Medical Center. Both Accountable Care Organizations are working with the Centers for Medicare and Medicaid Services to provide Medicare beneficiaries with higher quality care, while reducing growth in Medicare expenditures through enhanced care coordination. The Medicare Shared Savings Program facilitates the coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and to help reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization.

Federally Qualified Health Center Advanced Primary Care Practice

The Federally Qualified Health Center Advanced Primary Care Practice Demonstration led by the Centers for Medicare and Medicaid Services and the Health Resources and Services Administration is testing the effectiveness of the Patient Centered Medical Home model in improving the quality of care, promoting better health, and lowering costs.

Beacon Community

The Southeast Michigan Beacon Community is one of 17 Beacon communities building and strengthening local health information technology infrastructure and testing innovative approaches to make measurable improvements in health, care and cost. Meaningful Use of electronic health records is the foundation of the exciting work in each community. Funded by the Office of the National Coordinator for Health Information Technology, the Southeast Michigan Beacon Community is using technology to reduce the devastating effects of diabetes in its region.

Michigan Center for Effective IT Adoption

The Michigan Center for Effective IT Adoption operates under the Health Information Technology for Economic and Clinical Health Act, which established Centers for Medicare & Medicaid Services' programs to provide incentive payments for the Meaningful Use of certified electronic health record technology. As part of the act, regional extension centers were established to accelerate the adoption of health information technology to improve quality care delivery. Michigan Peer Review Organization, United Physicians, Upper Peninsula Health Care Network, Michigan Public Health Institute and Altarum Institute participate with the Michigan Center for Effective IT Adoption, Michigan's regional extension center, which is a non-profit statewide collaborative funded by the Department of Health and Human Services. This collaboration assists primary care providers with the facilitation of electronic health record adoption, implementation, and optimization. Team members provide information to increase the efficiencies of the electronic health record, achieve increased levels of quality, and attain Meaningful Use.

Oral Health Disease Prevention Program

The Oral Health Disease Prevention Program is funded by the Centers for Disease Control and Prevention. The goal of this grant program is to assist State health departments in improving the oral health of their residents, in particular those children and adults who are most at risk for oral diseases such as tooth decay or cavities. Michigan plans to enhance and sustain the expansion of the Michigan School-based Dental Sealant program, enhance the Community Water Fluoridation program to address the health and safety promotion of community water fluoridation, and implement preventive programs to enhance access to oral health services.

Office of Services to the Aging

The Office of Services to the Aging provides leadership on aging at the State level, as serving Michigan's older adult population is a collaborative process. The Office of Services to the Aging works closely with governing bodies and advisory groups to shape policy and address the concerns of older adults across the State. Through an open and collaborative process, the Office of Services to the Aging and its partners determine the vision for aging services in the State of Michigan.

Health Resources and Services Administration

Michigan was awarded $167,062,075 in Health Resources and Services Administration grants through 75 grantees in the following areas:

- Primary health care centers to operate clinics and mobile health medical vans, providing affordable primary and preventive care on a sliding fee scale to nearly 15 million low-income children and adults.
- National Health Services Corps is a network of primary medical, dental and behavioral health care professionals and sites that serve the most medically underserved regions of the country. To support their service, National Health Services Corps' clinicians receive financial support in the form of loan repayment and scholarships, as well as educational, training and networking opportunities.
- Health professions workforce training programs increase access to health care through the development, distribution and retention of a diverse, culturally competent health workforce that can adapt to the population's changing health care needs and provide the highest quality of care for all. Health professions programs support health professions schools and training programs in medicine, nursing, dentistry and public health. Grant recipients are health professions school and training programs.
- Rural health programs fund community health pilots and demonstrations in rural communities, support the State Offices of Rural Health in partnership with the State, expand the use of telehealth, support small rural hospitals, fund black lung clinics, and fund radiation exposure screening and education.
- The Ryan White HIV/AIDS Program targets resources to an array of programs at the State and local levels where they are most needed. The Ryan White HIV/AIDS Program, through Part A, B, C, D, and F grants, provides medical and support services to more than a half million people each year who would otherwise be unable to afford care.
- Michigan Title V Maternal and Child Health Block Grants, Home Visiting Formula Grants and Special Projects of Regional and National significance fund a variety of programs including services and support to children with special health care needs, systems for people with traumatic brain injuries, autism research, improvement of emergency medical services' systems capacity for treatment of children, newborn screening, family to family health information centers, sickle cell projects, and the Healthy Start Program.
- Health care systems grant programs promote organ donation and poison control centers and help States expand access to affordable health care coverage.
- Health information technology grants improve the quality of health care safety nets and improve efficiency. With technology like electronic health records, providers have access to accurate and complete information about a patient's health, and can better coordinate care. In Michigan, the Michigan Primary Care Association, located in Lansing provides technical assistance.

Implementing Evidence-Based Prevention Practices in Schools

The Elkton-Pigeon-Bay Port Laker School District, along with the Caseville School District is participating in the Substance Abuse and Mental Health Services Administration's Implementing Evidence-Based Prevention Practices in Schools (Short: Prevention Practices in Schools). Both cooperating school districts are well above 50% free and reduced meal eligible and both are Local Education Agencies, thus meeting the minimum requirements for this grant. With a well-established Positive Behavior Support framework already developed, it has become obvious to the applying school districts, that Positive Behavior Support is just a framework, and more behavioral intervention tools are needed. The Good Behavior Game will be such a tool as it is both researched and user friendly. It will provide classroom teachers the training and materials needed to improve classroom management, thereby improving student behavior and psycho-emotional status. These improvements are desperately needed at this time due to a huge shortage (nearly an absence) of behavioral interventionists in these buildings. With unemployment rates of 15.9%, increased financial/family/social stress, and resulting increasing student behavioral concerns, these elementary schools are in great need of the Good Behavior Game program.

Appendix 2.2: Existing demonstration and waivers granted to the State by the Centers for Medicare and Medicaid Services

Comprehensive Healthcare Program

1915 (b) Michigan Comprehensive Healthcare Program is the waiver authority that permits the State to require Medicaid enrollees to obtain services from Managed Care Organizations who meet certain reimbursement, quality, and utilization standards. The implementation of Michigan's 1915 (b) Waiver Program, the Comprehensive Healthcare Program began in 1996. Currently, Michigan contracts with 13 Managed Care Organizations to provide a comprehensive set of health care services for over 1.2 million of the State's Medicaid beneficiaries. The Managed Care Organization coverage includes a limited benefit for outpatient behavioral health services for persons with mild to moderate illness; persons with severe mental illness, intellectual/developmental disabilities, and substance use disorders are served through the Managed Specialty Community Mental Health Services and Supports waiver.

Throughout the implementation of the Michigan Comprehensive Healthcare Program, Michigan has maintained and expanded the emphasis on pay for performance. Key components of this approach are the auto-assignment algorithm, monthly performance monitoring reports, and the performance bonus award program. Each of these initiatives involves tracking Managed Care Organization performance for key performance measures across time using Healthcare Effectiveness Data and Information Set, Consumer Assessment of Healthcare Providers and Systems, encounter data and other sources. The auto-assignment algorithm is modified quarterly and allows Michigan to auto-assign beneficiaries into plans based on performance.

Managed Specialty Program and Services Program

Michigan operates the Managed Specialty Program and Services Program through 1915 (b)(1) and 1915(b)(4) authorities. Under this waiver authority, the State operates a program for Managed Specialty Community Mental Health Services & Supports through Michigan's public, county-based Community Mental Health Services Programs. The approval also permits Michigan to use 1915(a)(1)(A) capitation payments to provide more flexible, alternative services on an individual basis in lieu of State Plan coverage. In October of 1988, Community Mental Health Services and Supports became Specialty Prepaid Health Plans and began receiving capitated payments to provide services to Medicaid beneficiaries who were eligible for specialty services & supports. Medicaid health care services (e.g., physician services, hospital services etc.) are not included in the service program and are provided by a

Managed Care Organization enrolled health care provider.

The 1915(b) waiver operates in conjunction with Michigan's existing 1915(c) Habilitation Supports Waiver for people with developmental disabilities. Children with developmental disabilities who live with their birth or adoptive families are enrolled in the Children's Waiver Program and are exempt from the Managed Specialty Supports and Services Program.

Home and Community-Based Services Waiver

1. 1915 (c) MI Habilitation Supports- Michigan operates the Medicaid Home and Community-Based Services waiver program under §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

   Through this waiver, the State provides out-of-home non-vocational habilitation, prevocational services, respite, supported employment, supports coordination, enhanced medical equipment and supplies, enhanced pharmacy, goods and services, community living supports, environmental mods, family training, Personal Emergency Response Systems and private duty nursing for individuals with developmental disabilities with no age limits.

1. MI Choice Waiver Program or helps eligible adults receive Medicaid-covered services like those provided by nursing homes, but can stay in their own home or another residential setting.

2. 1915 (c) MI Waiver for Children with severe emotional disturbance- Provides respite, child therapeutic foster care, community living supports, community transition, family home care training, family support and training, home care training-non-family, therapeutic activities, therapeutic overnight camping, wraparound for individuals with mental illness/severe emotional disturbance ages 0-20.

3. 1915 (c) MI Children's Waiver Program- Provides respite, enhanced transportation, fiscal intermediary, community living supports, environmental accessibility adaptation s and specialized medical equipment and supplies, home care training-family, home care training-non-family, specialty service for individuals with autism, mental retardation, or developmental disabilities ages 0-17.

1115 Demonstration Waivers

1. Michigan operates the Michigan Adult Benefit Waiver under a section 1115 waiver authority. This program is designed to provide limited outpatient ambulatory benefits to non-pregnant adults, ages 19 to 64 years, who are uninsured with very low incomes. The Adult Benefit Waiver provides benefits through a network of county administered health plans. Presently there are 69,772 enrollees in the program. Enrollees are very low income childless adults that will qualify for full Medicaid benefits when the Medicaid expansion becomes effective in April 2014.

2. §1915(b)(4) Fee-for-Service Selective Contracting Waiver -Michigan operates §1915(b)(4) Fee-for-Service Selective Contracting Waiver to operate concurrently with the §1915(c) Home and Community Based Services Children's Waiver Program effective October 1, 2011. The §1915(b)(4) Fee-for-Service Selective Contracting Waiver provides services that are additions to

Medicaid State Plan coverage for children with developmental and intellectual disabilities up to the child's 18th birthday. The waiver permits the State to provide an array of community based services to enable children who meet "ICF/MR-DD" level-of-care to remain in their home and community.

3. Michigan also operates a §1915(b)(4) Fee-for-Service Selective Contracting Waiver concurrently with the §1915(c) Home and Community Based Services Waiver for Children with Serious Emotional Disturbances, effective April 1, 2012. The §1915(b)(4) Fee-for-Service Selective Contracting Waiver provides services that are additions to Medicaid State Plan coverage for children with serious emotional disturbances up to the child's 21st birthday. The waiver permits the State to provide an array of community based services to enable children who would otherwise require hospitalization in Michigan's State Psychiatric hospital for children (Hawthorn Center) to remain in their home and community.

4. 1115 Michigan EPIC Ex 1115 Pharmacy Plus demonstration waiver intended to match federal funds to expand the pharmacy benefits currently offered through the state funded Elder Prescription Insurance Coverage Program to individuals who may qualify for Medicaid.

5. 1115 FP- Plan First! Family Planning Demonstration provides coverage for family planning and family planning-related services to women, ages 19-44, with family incomes at or below 185 percent of the federal poverty line who are not otherwise eligible for Medicaid or the State's Health Insurance Flexibility Accountability Demonstration, and do not have other health insurance coverage that provides family planning services.

Multi-payer Advanced Primary Care Practice Demonstration

The Michigan Primary Care Transformation demonstration project is a three-year multi-payer project aimed at improving health in the state, making care more affordable, and strengthening the patient-care team relationship. The Michigan Primary Care Transformation collaborative is statewide in scope and is the largest Patient Centered Medical Home project in the nation. Approximately 400 primary care practices and 1,900 primary care physicians and mid-level providers affiliated with one of 35 physician/physician hospital organizations are currently receiving payments.

Assistance and support for practice transformation takes place through a collaborative network of physician/physician hospital organizations and shared learning opportunities facilitated by the Michigan Primary Care Transformation collaborative administrative staff. Focus areas for transformation under the demonstration include care management, self-management support, care coordination and linkages to community services.

The project is working toward a common incentive model across health plans, and provides clinical models, resources and support aimed at avoiding emergency room and inpatient use for ambulatory sensitive conditions, reducing fragmentation of care among providers and involving the patient in decision-making.

Integrated Care for People Eligible for Medicare and Medicaid

Integrated Care for People Eligible for Medicare and Medicaid is sponsored by the Michigan Department of Community Health. Michigan is one of fifteen states selected by Centers for Medicare & Medicaid Services to test models that better integrate primary, acute, behavioral health and long term services and supports and better align the financing of the Medicare and Medicaid programs for persons "dually eligible" for services under both programs. As a selected demonstration participant, Michigan worked with stakeholder groups to design a program specific to the state that would meet requirements for

coordinating and managing supports and services for the target population. The state currently has divided the 83 counties into ten regions for purposes of administering the waiver programs. Four of the regions have been selected for the demonstration program. The four regions (broken out by county) are as follows:

1. Region 1: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft
2. Region 4: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties
3. Region 7: Wayne County
4. Region 9: Macomb County

Under the demonstration, Michigan will test the Capitated Model whereby the state, the Centers for Medicare & Medicaid Services, and health plans enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care. Michigan and Centers for Medicare & Medicaid Services will selectively award performance and risk based contracts to entities that serve as Integrated Care Organizations. Integrated Care Organizations must have the ability to coordinate and manage comprehensive physical health care, long-term supports and services, and pharmacy services. In addition, the Integrated Care Organizations must coordinate with Prepaid Inpatient Health Plans to manage behavioral health, intellectual /developmental disabilities, and substance use disorder services.

The Care Bridge is the care coordination model developed to integrate supports and services and establish communication linkages. The Care Bridge includes an electronic platform that supports an Individualized Integrated Care and Supports Plan developed through a person-centered planning process. The enrollee must be offered an Integrated Care Team to work collaboratively with the enrollee to ensure the Integrated Care and Supports Plan is carried out according to the enrollee's preferences. The Integrated Care team members monitor and update the Integrated Care and Supports Plan for their respective areas of responsibility. Enrollment of dual eligibles into the demonstration program is expected to begin September 2014.

Healthy Michigan Plan

On September 16, 2013, Michigan Governor Rick Snyder signed into law a bill that enables the state to accept up to $1.7 billion in federal funding during fiscal year 2014 to begin enrolling approximately 400,000 low-income adults who are newly eligible into Medicaid. The majority of newly eligible persons will be enrolled into Medicaid Managed Care Organizations. The law also requires the state to obtain a waiver of some federal regulations from the Department of Health and Human Services to allow implementation of state-mandated reforms contained in the bill. Michigan will seek to amend the current 1115 demonstration waiver to accommodate the reform provisions. Included in the state mandated reform is a health savings like account for individuals or employers to deposit funds to cover incurred health expenses, including but not limited to copayments. The plan includes new financial incentives for beneficiaries engaging in healthy behaviors that include completion of an annual health risk assessment. The Managed Care Organizations will be eligible for financial bonuses for effectively managing enrollee cost sharing and for achieving cost and quality targets.

Appendix 2.3: Other Ongoing Initiatives

Comprehensive Community-Based Approach to Reducing Inappropriate Imaging

Comprehensive Community-Based Approach to Reducing Inappropriate Imaging is a multifaceted intervention taking place in Southeast Michigan to establish a data exchange system between primary care and imaging facilities to increase evidence-based decision-making among physicians ordering magnetic resonance imaging and computed tomography scans in the lumbar-spine, cervical-spine, lower extremities, shoulder, head, chest and abdomen. The goal is to reduce computed tomography volume by 17.4 percent and magnetic resonance imaging volume by 13.4 percent over three years, resulting in a 17 percent reduction in imaging costs without any loss in diagnostic accuracy or restrictions on the ordering of tests. The project is a partnership between Altarum Institute, United Physicians, and the Detroit Medical Center.

Navigator Grants

Four Michigan organizations received Navigator Grants to help consumers access and use the marketplace: Michigan Consumers for Healthcare, Community Bridges Management Inc., Arab Community Center for Economic & Social Services, and American Indian Health & Family Services of Southeast Michigan.

Mobility: the 6th Vital Sign

Mobility: the 6th Vital Sign is a project at the Henry Ford Health System, to develop an innovative care model to encourage and support patient mobility during acute inpatient hospitalizations. The intervention will address the hazards of immobility during hospitalization, including dehydration, malnutrition, delirium, sensory deprivation, isolation, shearing forces on skin, pressure ulcers, and respiratory complications. Henry Ford Health System expects to reduce hospital-acquired pressure ulcers and ventilator-associated pneumonia, improve quality of care and patient experience of care, and decrease length of stay in the hospital. Over a three-year period, the Henry Ford Health System will train approximately 21 health care providers, including physical therapists and wound- and ostomy-certified nurses.

Community-Based Care Transitions Programs

1. Michigan Area Agency on Aging 1-B in partnership with southeast Michigan hospitals William Beaumont-Troy, Henry Ford Health System Macomb, Henry Ford Health System Macomb-Warren Campus and Pontiac Osteopathic Hospital; nursing homes; skilled home care agencies, and hospice agencies, it will target Medicare fee-for-service beneficiaries in the designated medically underserved areas in Oakland and Macomb counties, Michigan. This coverage area includes a diverse range of populations in the greater Detroit area, ranging from urban to sparsely populated northern communities.

2. St. John Providence Health System, located in Warren, Michigan, it will partner with Adult Well Being Services to deliver care intervention to Medicare beneficiaries in Detroit (Wayne County), and Macomb and Southern Oakland Counties. The hospital partnership includes St. John Hospital and Medical Center, Providence Hospital and Medical Center, and St. John Macomb-Oakland Hospital. The care transition services will serve beneficiaries who predominantly reside in an urban area.

3. The Senior Alliance, Area Agency on Aging 1-C, located in Wayne, Michigan, it will provide care transitions services across 34 communities in southern and western Wayne County. The Senior Alliance will partner with six hospitals that include Garden City Hospital, St. Mary Mercy Hospital, Oakwood Hospital and Medical Center, Oakwood Annapolis Hospital, Oakwood

Heritage Hospital, and Oakwood Southshore Medical Center.

4. Tri-County Aging Consortium has partnered with two regional hospitals, Edward W Sparrow Hospital and Ingham Regional Medical Center, and the Chronic Disease Management Collaborative to serve Medicare beneficiaries residing in Clinton, Eaton, and Ingham counties in mid-Michigan (including cities of Lansing and East Lansing). The primary interventions use Project BOOST and the Bridge Model of Transitional Care. The tri-county partnership leverages its prior cooperative structure dating back to 2008.

5. Valley Area Agency on Aging, located in Flint, Michigan's Valley Area Agency on Aging will coordinate and lead the area's Transforming Transitions Project across central Michigan. Tailored to the area's unique demographics, the Project will implement a modified Better Outcomes for Older adults through Safe Transitions across all partnering hospitals. Building off successful prior transitions experience, the Project will include Hurley Medical Center, McLaren-Flint, Genesys Regional Medical Center, Owosso Memorial Hospital, and McLaren-Lapeer Region

Michigan Medicare/Medicaid Assistance

Michigan Medicare/Medicaid Assistance works through the area agencies on aging to provide high quality and accessible health benefit information and counseling. It is supported by a statewide network of unpaid and paid skilled professionals.

The Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly is a capitated benefit authorized by the Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated Medicare and Medicaid financing for frail, elderly individuals that meet Long Term Care level of care criteria.

Partnerships with Other CMS Innovation Projects

1. Care Management of Mental and Physical Co-Morbidities: a Triple Aim Bulls-Eye, led by the Institute for Clinical Systems Improvement of Bloomington, Minnesota to improve care delivery and outcomes for high-risk adult patients with Medicare or Medicaid coverage who have depression plus diabetes or cardiovascular disease.

2. Using Care Managers and Technology to Improve the Care of Patients with Schizophrenia, led by the Feinstein Institute for Medical Research to develop a workforce that is capable of delivering effective treatments, using newly available technologies, to at-risk, high-cost patients with schizophrenia. The intervention will test the use of care managers, physicians, and nurse practitioners trained to use new technology as part of the treatment regimen for patients recently discharged from the hospital at community treatment centers in nine states.

3. Medical Neighborhood Development Project is led by TransforMED, in partnership with 12 Veterans Health Administration affiliated hospitals for a primary care redesign project to support care coordination among Patient Centered Medical Homes, specialty practices, and hospitals, creating "medical neighborhoods." The project will use a sophisticated analytics engine to identify high risk patients and coordinate care across the medical neighborhood while driving Patient Centered Medical Home transformation in a number of primary care practices in each community.

4. Engaging Patients Through Shared Decision Making: Using Patient and Family Activators to Meet the Triple Aim lead by Dartmouth College in partnership with 15 large health systems from around the country. They hire Patient and Family Activators to engage in shared decision making

with patients and their families, focusing on preferences and supplying sensitive care choices. Patient and Family Activators may work with patients at a single decision point or over multiple visits for those with chronic conditions. It is anticipated that this intervention will lead to a reduction in utilization and costs and provide invaluable data on patient engagement processes and effective decision making—leading to new outcomes measures for patient and family engagement in shared decision making.

Mental Health Transformation Incentive Grant

1. Network180 is funded through a Substance Abuse and Mental Health Services Administration Mental Health Transformation Incentive Grant to fund the way services are delivered to young adults at risk of mental illness providing a consumer driven, recovery oriented and trauma informed system of supports and services that is based on evidence practices of Motivational Interviewing and Seeking Safety. The system transformation to trauma informed care will be extended throughout Kent County, Michigan, supported by the Creating Cultures of Trauma Informed Care change process. Services will be designed to identify and address recognized risk factors of mental illness, starting with young adults, and will provide outreach, screening and early intervention services based on culturally competent behavioral health care specifically designed for adults age 18-25 with noted risk factors. The service project will serve 500 young adults (100 new adults each year) over the course of 5 years. While all of these young adults will have significant trauma in common, they will vary in their stages of development as well as cultural backgrounds. This project will provide an alternative to traditional adult service models that are not well suited to a youth culture and their developmental needs.

2. Peers Employed in Evidence-based Practice for Recovery will combine the dual efforts of peer-driven mental health system transformation and the implementation of evidence-based practices for adults with serious mental illness. The project will integrate and evaluate the impact of peer services embedded in evidence-based practices on outcomes and system change throughout the Southwest region of Michigan. This initiative will employ the recovery oriented workforce in Southwest Michigan to provide the infrastructure, workforce development, fidelity and outcome monitoring, and program evaluation to successfully employ peers in established Supported Housing, Supported Employment, Integrated Dual Disorder Treatment, Assertive Community Treatment, and Supported Education. These practices will establish partnerships with individuals served to assure that they achieve the life they want. Peers Employed in Evidence-based Practice for Recovery will include peer-run and traditional mental health service organizations that serve adults with serious mental health. Individual outcomes will be determined using the National Outcomes Measurement System tool reported in the Transformation Accountability System, and the Illness Management and Recovery individual recovery measure. Peers Employed in Evidence-based Practice for Recovery will employ the Recovery Self-Assessment and use focus groups to assess organizational change. Finally, fidelity scales (both Treatment and General Organizational Indexes) will be utilized to determine the degree of fidelity to the evidence-based model. They hope to add to the evidence of the efficacy of employing peers in existing Evidence-Based Practices on individual and system outcomes. This Mental Health Transformation State Incentive Grant project is funded by the Substance Abuse and Mental Health Services Administration.

Child Mental Health Initiative

1. The Community Family Partnership of Kent County, Michigan extends its existing cross-agency efforts to a broader unified network of all county providers serving children with serious emotional disturbances and their families as well as regionalizing with other Child Mental Health Initiative grantees. The Community Family Partnership emphasizes on-going leadership and

governance of families, youth, and system stakeholders while incorporating practices that affirm community diversity. The Community Family Partnership's individualized strengths-based approach to services recognizes the importance of family, school, and community and addresses the child's physical, emotional, educational, cultural, linguistic and social needs while providing supports to maximize their greatest potential. This Child Mental Health Initiative is funded by the Substance Abuse and Mental Health Services Administration.

5. The Saginaw System of Care will transform the local service delivery system and create a vision to maximize the potential of children, youth, and their families to achieve full involvement and inclusion in their community, and become self-sufficient, safe, healthy, and productive. The project will target families with children and youth experiencing serious emotional disturbances, aged 6 to 17, experiencing difficulties in school, at home, and/or in the community and require the services and supports of two or more child-serving systems (mental health, juvenile justice, child welfare, or special education). The Saginaw System of Care will serve 500 children over the 6 years of Federal funding. The cornerstone of this endeavor is the authentic inclusion of youth and family voice and choice not only in the development and provision of individualized services, but also in the transformation of the service delivery system to provide culturally and linguistically competent, strengths-based, family-driven, youth-guided care. Child Mental Health Initiative is funded by the Substance Abuse and Mental Health Services Administration.

Michigan's Linking Actions for Unmet Needs in Children's Health
Michigan's Linking Actions for Unmet Needs in Children's Health is a Department of Community Health project funded by the Substance Abuse and Mental Health Services Administration to improve the comprehensive wellness of all young children 0-8 and their families by using the public health approach to expand and enhance early childhood systems of care. The program will increase the use of evidence-based practices such as Healthy Families America, Parents as Teachers, Incredible Years, Parenting Wisely, Mental Health Consultation and the Ages and Stages Questionnaire that promote comprehensive wellness as well as the integration of behavioral health into primary care. Michigan's Linking Actions for Unmet Needs in Children's Health will partner with Saginaw County, population 205,000. Seventy percent of the population to be served by the program in Saginaw will be drawn from its largest city and 30% from its rural, isolated hamlets. This program will impact 1,000-1,500 children per year during its five year project period, resulting in up to 7,000 children receiving the direct benefit of the project.

The Respecting, Engaging, Supporting, Protecting, Empowering, Connecting, and Teaching Project
The American Indian Health and Family Services of Southeast Michigan's Manidookewigashkibjigan Sacred Bundle: Respecting, Engaging, Supporting, Protecting, Empowering, Connecting and Teaching Project, a Garrett Lee Smith State and Tribal Youth Suicide Prevention Grant, serves primarily American Indian/Alaska Native youth and young adults age 10-24, in Detroit and Southeastern Michigan, in collaboration with State and County Suicide Prevention authorities, through evidence-based practice interventions and treatment strategies as well as culturally infused Practice-Based Evidence. The goals of the project are to: (1) increase the number of persons in youth serving organizations such as schools, foster care systems, juvenile justice programs, trained to identify and refer youth at risk for suicide; (2) increase the number of health, mental health, and substance abuse providers trained to assess, manage and treat youth at risk for suicide; increase the number of youth identified as at risk for suicide; (3) increase the number of youth at risk for suicide referred for behavioral health care services; (4) increase the number of youth at risk for suicide who receive behavioral health care services; (5) increase the promotion of the National Suicide Prevention Lifeline.

Neighborhood Service Organization Bridges Program

Neighborhood Service Organization Bridges Program will provide a comprehensive program offering supportive drug/alcohol and mental health services to chronically homeless persons placed into supportive housing in the Detroit area. The Bridges Program will provide focused and intensive case management following an Assertive Community Treatment model to address the multiple needs of people suffering from mental illness and substance abuse, and who may also experience the effects of physical and mental trauma, and physical disability. The Integrated Dual Disorder Treatment model will be engaged to provide comprehensive treatment, from a recovery perspective, with consumers. The Neighborhood Service Organization Bridges Program will work with 65 individuals the first two years of the program, and will expand by 25 persons per year in year's 3 to 5. People who drop out (they predict a 75% retention rate) will be replaced by others, resulting in service over the five years of the grant to 206 unduplicated consumers.

Southwest Counseling Solutions

Southwest Counseling Solutions in Detroit will provide Assertive Community Treatment and Integrated Dual Disorders Treatment using Motivational Interventions in combination with Permanent Supportive Housing and a Housing First Model to chronically homeless individuals to achieve housing stability, improved psychiatric functioning and quality of life, and decreased substance use. Over the five year project period this project proposes to serve 120 individuals. Program goals include: 1) maintaining safe and affordable housing for a minimum of 12 months after securing a residence and signing a lease; 2) improve symptoms of mental illness and/or reduce substance use within the first 12 months of being housed; and 3) identify and improve in one life domain that will contribute towards long term recovery and housing stability.

Washtenaw Community Health Organization

The Washtenaw Community Health Organization will use the supplemental Substance Abuse and Mental Health Services Administration grant funds for the enhancement and certification of the Wellness Plan, a fully integrated electronic health record that includes a dashboard of behavioral and physical health parameters, clinical information from behavioral and physical health providers, and outcomes data related to each. These sources of information will populate the various databases developed within the new electronic health record. The development of this system will achieve Stage 1 for electronic health record Meaningful Use specification; as well as provide for the development and implementation of an appropriate health information exchange; and the use of the exchange of health information to achieve improved health outcomes for consumers. The project will document the progress made as the electronic health record is implemented, and health data is shared between providers to identify barriers faced in achieving the desired goals and the adjustments required to overcome any challenges.

Appendix 2.4: Patient Centered Medical Home Crosswalk: Joint Principles, National Committee on Quality Assurance 2011, & Blue Cross Blue Shield of Michigan

1. Map between BCBSM and current NCQA criteria included in the MiPCT Proposal
2. This version updated to reflect 2011 Committee for Quality Assurance Standards
3. BCBSM criteria come from V4.2 2012-2013 Interpretive Guidelines
4. Joint Principles are sub-headings in grey shaded rows, developed by AAP, AAFP, ACP, and AOA, in February 2007
5. *** indicates Committee for Quality Assurance Must Pass Elements

NCQA 2011	BCBSM
Personal relationship with a care provider	
PCMH 1D: Continuity 1. Expecting patients/families to select a personal clinician 2. Documenting the patient's/family's choice of clinician 3. Monitoring the percentage of patient visits with a selected clinician or team.	2.5 Registry contains information on the individual attributed practitioner for every patient currently in the registry who has a medical home in the practice unit
PCMH 1E: Medical Home Responsibilities The practice has a process and materials that it provides patients/families on the role of the medical home, which include the following: 1. The practice is responsible for coordinating patient care across multiple settings 2. Instructions on obtaining care and clinical advice during office hours and when the office is closed 3. The practice functions most effectively as a medical home if patients/families provide a complete medical history and information about care obtained outside the practice 4. The care team gives the patient/family access to evidence-based care and self-management support	1.0 Patient Provider Partnership 1.1 Practice unit has developed PCMH-related patient communication tools, has trained staff, and is prepared to implement patient-provider partnership with each established patient, which may consist of a signed agreement or other documented patient communication process to establish patient-provider partnership 1.2 Process of reaching out to established patients is underway, and practice unit is using a systematic approach to inform patients about PCMH, including patients who do not visit the practice regularly 1.3 [1.4, 1.5, 1.6, 1.7, 1.8] Patient-provider agreement or other documented patient communication process is implemented and documented for at least 10% of current patients [30%, 50%, 60%, 80%, 90% - respectively]
Interprofessional care teams collectively take responsibility for the ongoing care of patients	
PCMH1G: The Practice Team The practice provides a range of patient care services by: 1. Defining roles for clinical and nonclinical team members 2. Having regular team meetings and communication processes 3. Using standing orders for services 4. Training and assigning care teams to	4.1 Practice Unit leaders and staff have been trained/educated and have comprehensive knowledge of the Patient Centered-Medical Home model, the Chronic Care model, and practice transformation concepts 4.2 Practice Unit has developed an integrated team of multi-disciplinary providers and a systematic

coordinate care for individual patients 5. Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change 6. Training and assigning care teams for patient population management 7. Training and designating care team members in communication skills 8. Involving care team staff in the practice's performance evaluation and quality improvement activities	approach is in place to deliver coordinated care management services that address patients' full range of health care needs for at least one chronic condition Other domains refer to care teams, training of all members of care teams, roles that must be assigned to care team members, and having systematic approaches in place to ensure appropriate provision.

Whole person orientation – the interprofessional care team is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

PCMH2C: Comprehensive Health Assessment To understand the health risks and information needs of patients/families, the practice conducts and documents a comprehensive health assessment that includes: 1. Documentation of age- and gender-appropriate immunizations and screenings 2. Family/social/cultural characteristics 3. Communication needs 4. Medical history of patient and family 5. Advance care planning (NA for pediatric practices) 6. Behaviors affecting health 7. Patient and family mental health/substance abuse 8. Developmental screening using a standardized tool (children) 9. Depression screening for adults and adolescents using a standardized tool.	4.18 A systematic approach is in place for assessing patient palliative care needs and ensuring patients receive needed palliative care services 9.1 Primary prevention program is in place that focuses on identifying and educating patients about personal health behaviors to reduce their risk of disease and injury 9.3 Strategies are in place to promote and conduct outreach regarding ongoing well care visits and screenings for all populations, consistent with guidelines for such age and gender-appropriate services promulgated by credible national organizations

PCMH4A: Support Self-care Process *** The practice conducts activities to support patients/families in self-management: Enter the percentage of patients for each factor ■ Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management ■ Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate** ■ Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families ■ Documents self-management abilities for at	4.11 Action plan development and goal-setting is systematically offered to all patients with chronic conditions or other complex health care needs prevalent in practice's patient population 11.0 Self-management Support 11.1 Member of clinical care team or PO is educated about and familiar with self-management support concepts and techniques and regularly works with appropriate staff members at the practice unit to ensure they are educated in and able to actively use self-management support concepts and techniques. 11.2, [11.5] Self-management support is offered to all patients with the chronic condition selected for initial focus

least 50 percent of patients/families ■ Provides self-management tools to record self-care results for at least 50 percent of patients/families ■ Counsels at least 50 percent of patients/families to adopt healthy behaviors	(based on need, suitability, and patient interest) 11.3 Systematic follow-up occurs for all patients with the chronic condition selected for initial focus who are engaged in self-management support to discuss action plans and goals, and provide supportive reminders 11.4 Regular patient experience/satisfaction surveys are conducted for patients engaged in self-management support, to identify areas for improvement in the self-management support efforts 11.5 Self-management support is offered to patients with all chronic conditions prevalent in the practice's patient population (based on need, suitability and patient interest) 11.6 Systematic follow-up occurs for patients with all chronic conditions prevalent in the practice's patient population who are engaged in self-management support to discuss action plans and goals, and provide supportive reminders 11.7 Support and guidance in establishing and working towards a self-management goal is offered to every patient, including well patients 11.8 At least one member of PO or practice unit is formally trained through completion of a nationally or internationally-accredited program in self-management support concepts and techniques, and regularly works with appropriate staff members at the practice unit to educate them so they are able to actively use self-management support concepts and techniques.
Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.	
PCMH3C: Care Management *** The care team performs the following for at least 75 percent of the patients identified in Elements A and B (important conditions & high risk): ■ Conducts pre-visit preparations ■ Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and	4.0 Individual Care Management 4.1 Practice Unit leaders and staff have been trained/educated and have comprehensive knowledge of the Patient Centered-Medical Home model, the Chronic Care model, and practice transformation concepts 4.2 Practice Unit has developed an integrated team of

updated at each relevant visit ■ Gives the patient/family a written plan of care ■ Assesses and addresses barriers when the patient has not met treatment goals ■ Gives the patient/family a clinical summary at each relevant visit ■ Identifies patients/families who might benefit from additional care management support ■ Follows up with patients/families who have not kept important appointments	multi-disciplinary providers and a systematic approach is in place to deliver coordinated care management services that address patients' full range of health care needs for at least one chronic condition 4.5 Development of written action plan and self-management goal-setting is systematically offered to all patients with the chronic condition selected for initial focus, with substantive patient-specific and patient-friendly documentation provided to the patient Systematic approach in place for the following: 4.6, [4.12] Appointment tracking and generation of reminders for all patients with the chronic condition selected for initial focus [and all patients] 4.7, [4.13] Ensure that follow-up for needed services is provided for all patients with the chronic condition selected for initial focus [all patients] 4.8, [4.14] Planned visits are offered to all patients with the chronic condition selected for initial focus [all patients with prevalent chronic diseases] 4.9, [4.15] Group visit option is available for all patients in the practice unit with the chronic condition selected for initial focus (as appropriate for the patient)[all prevalent chronic diseases] 4.16 Engaging patients in conversation about advance care planning, executing an advance care plan with each patient who wishes to do so, and including a copy of a signed advance care plan in the patient's medical record 4.17 Developing a survivorship plan for patients once treatment is completed, including a copy of the survivorship plan in the patient's medical record, and ensuring that the plan in shared with the patient's providers
PCMH3D: Medication Management The practice manages medications in the following ways: ■ Reviews and reconciles medications with patients/families for more than 50 percent of care transitions**	4.10 Medication review and management is provided at every visit for all patients with chronic conditions

- Reviews and reconciles medications with patients/families for more than 80 percent of care transitions

- Provides information about new prescriptions to more than 80 percent of patients/families

- Assesses patient/family understanding of medications for more than 50 percent of patients

- Assesses patient response to medications and barriers to adherence for more than 50 percent of patients

- Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families, with the date of updates

PCMH4B: Provides Referrals to Community Resources	10.0 Linkage to Community Services
The practice supports patients/families that need access to community resources: - Maintains a current resource list on five topics or key community service areas of importance to the patient population - Tracks referrals provided to patients/families - Arranges or provides treatment for mental health and substance abuse disorders - Offers opportunities for health education and peer support.	10.1 PO has conducted a comprehensive review of community resources for the geographic population that they serve, in conjunction with Practice Units 10.2 PO maintains a community resource database based on input from Practice Units that serves as a central repository of information for all Practice Units. 10.3 PO in conjunction with Practice Units has established collaborative relationships with appropriate community-based agencies and organizations 10.4 All members of practice unit care team involved in establishing care treatment plans have received training on community resources so that they can identify and refer patients appropriately 10.5 Systematic approach is in place for educating all patients about community resources and assessing/discussing need for referral 10.6 Systematic approach is in place for referring patients to community resources 10.7 Systematic approach is in place for tracking referrals of high-risk patients to community resources made by the care team, and making every effort to ensure that patients complete the referral activity

	10.8 Systematic approach is in place for conducting follow-up with high-risk patients regarding any indicated next steps as an outcome of their referral to a community-based program or agency.
PCMH5A: Test Tracking & Follow-up The practice has a documented process for and demonstrates that it: • Tracks lab tests until results are available, flagging and following up on overdue results • Tracks imaging tests until results are available, flagging and following up on overdue results • Flags abnormal lab results, bringing them to the attention of the clinician • Flags abnormal imaging results, bringing them to the attention of the clinician • Notifies patients/families of normal and abnormal lab and imaging test results • Follows up with inpatient facilities on newborn hearing and blood-spot screening • Electronically communicates with labs to order tests and retrieve results • Electronically communicates with facilities to order and retrieve imaging results • Electronically incorporates at least 40 percent of all clinical lab test results into structured fields in medical records • Electronically incorporates imaging test results into medical records	6.0 Test Results Tracking and Follow-up 6.1 Practice has test tracking process/procedure documented, which requires tracking and follow-up for all tests and test results, with identified timeframes for notifying patients of results Systematic approach in place for the following 6.2 Ensuring patients receive needed tests and practice obtains results 6.4 Patients to obtain information about normal tests 6.5 To inform patients about abnormal test results 6.6 To ensure that patients with abnormal results receive the recommended follow-up care within defined timeframes. 6.7 To document all test tracking steps in the patient's medical record 6.8 All clinicians and appropriate office staff are trained to ensure adherence to the test-tracking procedure; all training is documented either in personnel file or in training logs or records
PCMH5B: Referral Tracking & Follow-up *** The practice coordinates referrals by: ■ Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information ■ Tracking the status of referrals, including required timing for receiving a specialist's report ■ Following up to obtain a specialist's report ■ Establishing and documenting agreements with specialists in the medical record if co-management is needed ■ Asking patients/families about self-referrals and requesting reports from clinicians ■ Demonstrating the capability for electronic	14.0 Specialist Referral Process 14.1 Documented procedures are in place to guide each phase of the specialist referral process – including desired timeframes for appointment and information exchange - for preferred or high volume providers 14.2 Documented procedures are in place to guide each phase of the specialist referral process – including desired timeframes for appointment and information exchange – for other key providers 14.3 Directory is maintained listing specialists to whom patients are routinely referred 14.4 PO or Practice Unit has developed specialist referral materials supportive of process and

exchange of key clinical information (e.g., problem list, medication list, allergies, diagnostic test results) between clinicians* ■ Providing an electronic summary of the care record for more than 50 percent of referrals.**	individual patient needs 14.5 Practice Unit or designee routinely makes specialist appointments on behalf of patients 14.6 Each facet of the interaction between preferred/high volume specialists and the PCPs at the Practice Unit level is automated by using electronically-based tools and processes to avoid duplication of testing and prescribing across multiple care settings 14.7 For all specialist and sub-specialist visits deemed important to the patient's well-being, process is in place to determine whether or not patients completed the specialist referral in a timely manner, reasons they did not seek care if applicable, additional sub-specialist visits that occurred, specialist recommendations, and whether patients received recommended services 14.8 Appropriate Practice Unit staff is trained on all aspects of the specialist referral process 14.9 Practice Unit regularly evaluates patient satisfaction with most commonly used specialists, to ensure physicians are referring patients to specialists that meet their standards for patient-centered care 14.10 Physician-to-physician pre-consultation exchanges are used to clarify need for referral and enable PCP to obtain guidance from specialists and subspecialists, ensuring optimal and efficient patient care.
PCMH5C: Coordinate with Facilities and Care Transitions On its own or in conjunction with an external organization, the practice systematically: I. Demonstrates its process for identifying patients with a hospital admission or emergency department visit II. Demonstrates its process for sharing clinical information with the admitting hospital or emergency department III. Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities IV. Demonstrates its process for contacting patients/families for appropriate follow-up care	13.0 Coordination of Care 13.1 For every patient with chronic condition selected for initial focus, mechanism is established for being notified of each patient admit and discharge or other type of encounter, at facilities with which the PCMH physician has admitting privileges or other ongoing relationships 13.2 Process is in place for exchanging necessary medical records and discussing continued care arrangements with other providers, including facilities, for all patients with chronic condition selected for initial focus 13.3

within an appropriate period following a hospital admission or emergency department visit V. Demonstrates its process for exchanging patient information with the hospital during a patient's hospitalization VI. Collaborates with the patient/family to develop a written care plan for patients transitioning from pediatric care to adult care (NA for adult only practices) VII. Demonstrates the capability for electronic exchange of key clinical information with facilities* VIII. Provides an electronic summary-of-care record to another care facility for more than 50 percent of transitions of care**	Approach is in place to systematically track care coordination activities for each patient with chronic condition selected for initial focus. 13.4 Process is in place to systematically flag for immediate attention any patient issue that indicates a potentially time-sensitive health issue for all patients with chronic condition selected for initial focus 13.5 Process is in place to ensure that written transition plans are developed, in collaboration with patient and caregivers, where appropriate, for patients with chronic condition selected for initial focus who are leaving the practice (i.e., because they are moving, going into a long-term care facility, or choosing to leave the practice). 13.6 Process is in place to coordinate care with payer case manager for patients with complex or catastrophic conditions 13.7 Practice has written procedures and/or guidelines on care coordination processes, and appropriate members of care team are trained on care coordination processes and have clearly defined roles within that process 13.8 Care coordination capabilities as defined in 13.1-13.7 are extended to all patients with chronic conditions that need care coordination assistance 13.9 Coordination capabilities as defined in 13.1-13.7 are extended to all patients that need care coordination assistance
Quality and safety: Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.	
PCMH1F: Culturally and Linguistically Appropriate Services The practice has a process and materials that it provides patients/families on the role of the medical home, which include the following: 1. The practice is responsible for coordinating patient care across multiple settings 2. Instructions on obtaining care and clinical advice during office hours and when the office is closed 3. The practice functions most effectively as a medical home if patients/families provide a	5.9 Practice unit has telephonic or other access to interpreter(s) for all languages common to practice's established patients.

complete medical history and information about care obtained outside the practice 4. The care team gives the patient/family access to evidence-based care and self-management support	
Quality and safety: Evidence-based medicine and clinical decision-support tools guide decision making	
PCMH2D: Use Data for Population Management*** The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients and to proactively remind patients/families and clinicians of services needed for: • At least three different preventive care services** • At least three different chronic care services** • Patients not recently seen by the practice • Specific medications	2.0: Patient Registry [paper or electronic] For population management, may be paper or electronic And 2.1 Diabetes; 2.11 CAD; 2.12 CHF; 2.13 Registry used to manage 2 other chronic diseases; 2.14 preventive care; 2.16 CKD; 2.17 Pediatric obesity; 2.18 Pediatric ADHD) 2.6 Registry is being used to generate routine, systematic communication to patients regarding gaps in care 2.7 Registry is being used to flag gaps in care for every patient currently in the registry
PCMH3A: Implement Evidence-based Guidelines The practice implements evidence-based guidelines through point-of-care reminders for patients with: 1. The first important condition* 2. The second important condition 3. The third condition, related to unhealthy behaviors or mental health or substance abuse	2.3 Registry incorporates evidence-based care guidelines 2.4 Registry information is available and in use by the Practice Unit team at the point of care 4.3 Systematic approach is in place to ensure that evidence-based care guidelines are established and in use at the point of care by all team members of the Practice Unit 4.4 PCMH patient satisfaction/office efficiency measures are systematically administered
PCMH3B: Identify High-risk Patients To identify high-risk or complex patients, the practice: ■ Establishes criteria and a systematic process to identify high-risk or complex patients ■ Determines the percentage of high-risk or complex patients in its population.	2.1 A paper or electronic all-payer registry is being used to manage all established patients in the Practice Unit with: Diabetes (or, for specialists, relevant condition) 2.2 Registry incorporates patient clinical information, for all established patients in the registry, for a substantial majority of health care services received at other sites that are necessary to manage chronic care and preventive services for the population
	9.0 Preventive Services 9.1 Primary prevention program is in place that focuses on identifying and educating patients about personal health behaviors to reduce their risk of

	disease and injury.
	9.2
	A systematic approach is in place to providing preventive services
	9.3
	Strategies are in place to promote and conduct outreach regarding ongoing well care visits and screenings for all populations, consistent with guidelines for such age and gender-appropriate services promulgated by credible national organizations
	9.4
	Practice has process in place to inquire about a patient's outside health encounters and has capability to incorporate information in patient tracking system or medical record
	9.6
	Written standing order protocols are in place allowing Practice Unit care team members to authorize and deliver preventive services according to physician-approved protocol without examination by a clinician
	9.7
	Secondary prevention program is in place to identify and treat asymptomatic persons who have already developed risk factors or pre-clinical disease, but in whom the disease itself has not become clinically apparent.
	9.8
	Staff receives regular training and/or communications in health promotion and disease prevention and incorporates preventive-focused practices into ongoing administrative operations

Quality and safety: Accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement

PCMH6A: Measure Performance The practice measures or receives data on the following: ■ At least three preventive care measures ■ At least three chronic or acute care clinical measures ■ At least two utilization measures affecting health care costs ■ Performance data stratified for vulnerable populations (to assess disparities in care).	3.0: Performance Reporting 3.1 Performance reports that allow tracking and comparison of results at a specific point in time across the population of patients are generated for: Diabetes 3.2 Performance reports are generated at the PO/Sub-PO, Practice Unit , and individual provider level 3.3 Performance reports include patients with at least 2 other chronic conditions for which there are evidence-based guidelines and the need for ongoing population and patient management, and which are sufficiently prevalent in the practice to warrant
PCMH6C: Implement CQI *** The practice uses an ongoing quality improvement process to:	

• Set goals and act to improve performance on at least three measures from Element A, and 1 measure from Element B • Set goals and address at least one identified disparity in care or service for vulnerable populations • Involve patients/families in quality improvement teams or on the practice's advisory council.	inclusion in the registry based on the judgment of the practice leaders 3.4 Data contained in performance reports has been fully validated and reconciled to ensure accuracy 3.5 Trend reports are generated, enabling physicians and their POs/sub-POs to track, compare and manage performance results for their population of patients over time 3.6 Performance reports are generated for the population of patients with: Pediatric Obesity 3.7 Performance reports include all current patients in the practice, including well patients, and include data on preventive services 3.8 Performance reports include patient clinical information for a substantial majority of health care services received at other sites that are necessary to manage chronic care and preventive services for the population 3.9 Performance reports include information on services provided by specialists 3.10, 3.11, 3.12, 3.13 Performance reports generated (respectively for) asthma, CAD, CHF, pediatric ADHD
PCMH6 D: Demonstrate CQI The practice demonstrates ongoing monitoring of the effectiveness of its improvement process by: 1) Tracking results over time 2) Assessing the effect of its actions 3) Achieving improved performance on one measure 4) Achieving improved performance on a second measure	
PCMH6 E: Report Performance Within the practice, results by individual clinician Within the practice, results across the practice Outside the practice to patients or publicly, results across the practice or by clinician.	

Quality and safety: Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met	
[See Element B re CAHPS survey, below]	

Quality and safety: Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication	
PCMH2 A: Patient Information The practice uses an electronic system that records the following as structured (searchable) data for more than 50 percent of its patients: 1. Date of birth* 2. Gender* 3. Race* 4. Ethnicity* 5. Preferred language* 6. Telephone numbers 7. E-mail address 8. Dates of previous clinical visits 9. Legal guardian/health care proxy 10. Primary caregiver 11. Presence of advance directives (NA for pediatric practices)	2.8 Registry incorporates information on patient demographics for all patients currently in the registry [paper or electronic] 2.9 Registry is fully electronic, comprehensive and integrated, with analytic capabilities 2.15 Registry incorporates patients who are assigned by managed care plans and are not established patients in the practice 6.3 Process is in place for ensuring patient contact details are kept up to date 6.7 Systematic approach is used to document all test

12. Health insurance information	tracking steps in the patient's medical record 6.9 Practice has Computerized Order Entry integrated with automated test tracking system
PCMH2 B: Clinical Information The practice uses an electronic system to record the following as structured (searchable) data: 1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients 2. Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients 3. Blood pressure, with the date of update for more than 50 percent of patients 4. Height for more than 50 percent of patients 5. Weight for more than 50 percent of patients 6. BMI for more than 50 percent of adult patients 7. Length/height, weight and head circumference (less than 2 years of age) and BMI percentile (2–20 years) for more than 50 percent of pediatric patients, with the capability to plot changes over time 8. Status of tobacco use for patients 13 years and older for more than 50 percent of patients 9. List of prescription medications with the date of updates for more than 80 percent of patients	2.2 Registry [paper or electronic] incorporates patient clinical information, for all established patients in the registry, for a substantial majority of health care services received at other sites that are necessary to manage chronic care and preventive services for the population [See 2.8 above, paper or electronic] [See 2.9 above, fully electronic & integrated] 9.5 Practice has a systematic approach in place to ensure the provision/documentation of tobacco use assessment tools and advice regarding smoking cessation
PCMH3 E: Uses Electronic Prescribing The practice uses an electronic prescription system with the following capabilities: ■ Generates and transmits at least 40 percent of eligible prescriptions to pharmacies* ■ Generates at least 75 percent of eligible prescriptions* ■ Integrates with patient medical records ■ Performs patient-specific checks for drug-drug and drug-allergy interactions* ■ Alerts prescribers to generic alternatives ■ Alerts prescribers to formulary status**	
PCMH6 F: Report Data Externally ✓ Ambulatory clinical quality measures to CMS* ✓ Data to immunization registries or systems** ✓ Syndromic surveillance data to public health agencies.**	
Quality and safety: Patients and families participate in quality improvement activities at the practice level	
PCMH6 B: Measure Patient/Family Experience The practice obtains feedback from	[See 11.4. measurement of patient satisfaction with self-management services]

patients/families on their experiences with the practice and their care.

- The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: Access, Communication, Coordination, Whole-person care

- The practice uses the Patient-Centered Medical Home version of the CAHPS Clinician Group survey tool

- The practice obtains feedback on the experiences of vulnerable patient groups

- The practice obtains feedback from patients/families through qualitative means.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.	
PCMH1 A: Access During Office Hours *** 1. Providing same-day appointments 2. Providing timely clinical advice by telephone during office hours 3. Providing timely clinical advice by secure electronic messages during office hours 4. Documenting clinical advice in the medical record.	5.7, [5.8] Advanced access scheduling is in place, reserving at least 30% [50%] of appointments for same-day appointments for acute and routine care (i.e., any elective non-acute/urgent need, including physical exams and planned chronic care services, for established patients)
PCMH1t B: After Hours Access The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for: 1. Providing access to routine and urgent-care appointments outside regular business hours 2. Providing continuity of medical record information for care and advice when the office is not open 3. Providing timely clinical advice by telephone when the office is not open 4. Providing timely clinical advice using a secure, interactive electronic system when the office is not open 5. Documenting after-hours clinical advice in patient records.	5.1 Patients have 24-hour access to a clinical decision-maker by phone, and clinical decision-maker has a feedback loop within 24 hours or next business day to the patient's PCMH 5.2 Clinical decision-maker accesses and updates patient's EMR or registry info during the phone call 5.3 Provider has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs during at least 8 after-hours per week and, if different from the PCP office, after-hours provider has a feedback loop within 24 hours or next business day to the patient's PCMH 5.4 A systematic approach is in place to ensure that all patients are fully informed about after-hours care availability and location, at the PCMH site as well as other after-hours care sites, including urgent care facilities, if applicable 5.5 Practice Unit has made arrangements for patients to have access to non-ED after-hours provider for

	urgent care needs (as defined under 5.3) during at least 12 after-hours per week <u>5.6</u> Non-ED after-hours provider for urgent care accesses and updates the patient's EMR or patient's registry record during the visit
<u>PCMH1 C: Electronic Access</u> The practice provides the following information and services to patients and families through a secure electronic system 1. More than 50 percent of patients who request an electronic copy of their health information (e.g., problem list, diagnoses, diagnostic test results, medication lists, allergies) receive it within three business days* 2. At least 10 percent of patients have electronic access to their current health information (including lab results, problem list, medication lists, and allergies) within four business days of when the information is available to the practice** 3. Clinical summaries are provided to patients for more than 50 percent of office visits within three business days* 4. Two-way communication between patients/families and the practice 5. Request for appointments or prescription refills 6. Request for referrals or test results	<u>12.0 Patient Web Portal</u> <u>12.1</u> Available vendor options for purchasing and implementing a patient web portal system have been evaluated <u>12.2</u> PO or Practice Unit has assessed liability and safety issues involved in maintaining a patient web portal at any level and developed policies that allow for a safe and efficient exchange of information <u>12.3</u> Ability for patients to request and schedule appointments electronically is activated and available to all patients <u>12.4</u> Ability for patients to log and/or graphs results of self-administered tests (e.g., daily blood glucose levels) is activated and available to all patients <u>12.5</u> Providers are automatically alerted by system regarding self-reported patient data that indicates a potential health issue <u>12.6</u> Ability for patients to participate in E-visits is activated and available to all patients <u>12.7</u> Providers are using patient portal to send automated care reminders, health education materials, links to community resources, educational web sites and self-management materials to patients electronically <u>12.8</u> Patient portal system includes capability for patient to create personal health record, and is activated and available to all patients <u>12.9</u> Ability for patients to review test results electronically is activated and available to all patients <u>12.10</u> Ability for patients to request prescription renewals electronically is activated and available to all patients <u>12.11</u>

	Ability for patients to graph and analyze results of self-administered tests for self-management support purposes is activated and available to all patients
	12.12
	Ability for patients to have access to view registries and/or electronic medical records online that contain patient personal health information that has been reviewed and released by the provider and/or practice is activated and available to all patients

Appendix 3

Appendix 3.1: Management Team Members

Last Name	First Name	Organization/Department	Title
Allen	Amy	Michigan Department of Community Health, Medical Services Administration	Health Care Reform
Bach-Stante	Deborah	Michigan Department of Community Health, Office of Nursing Policy	Director
Becker	Timothy	Michigan Department of Community Health, Operations Administration	Senior Deputy
Blakeney	Scott	Michigan Department of Community Health, Health Planning & Org Support Division; Policy & Planning Administration	Director
Brim	Melanie	Michigan Department of Community Health, Public Health Administration	Senior Deputy
Callaghan	Carol	Michigan Department of Community Health, Chronic Disease/ Injury Control Division; Public Health Administration	Director
Carr	Alethia	Michigan Department of Community Health, Bureau of Family, Maternal & Child Health; Public Health Administration	Director
Davis	Matt	Michigan Department of Community Health	Chief Medical Executive
Fink	Brenda	Michigan Department of Community Health, Division of Family & Community Health; Public Health Administration	Director
Fitton	Stephen	Michigan Department of Community Health, Medical Services Administration	Senior Deputy
Green-Edwards	Cynthia	Michigan Department of Community Health, Office of Medicaid Health Information Technology	Director
Hertel	Elizabeth	Michigan Department of Community Health, Policy & Planning	Senior Assistant
Kelly	Cynthia	Michigan Department of Community Health, Bureau of State Hospital & Behavioral Health Admin. Operations; Behavioral Health & Development Disability Admin.	Director
Knisely	Elizabeth	Michigan Department of Community Health, Bureau of Community Mental Health Services; Behavioral Health & Developmental Disability Administration	Director
Lasher	Geralyn	Michigan Department of Community Health, External Relations & Communication	Senior Deputy
Lyon	Nick	Michigan Department of Community Health	Chief Deputy Director
Middleton	Wendi	Michigan Department of Community Health, Program and Partnership Development Division; Michigan Office of Services to the Aging	Director
Miles	Dick	Michigan Department of Community Health, Bureau of Medicaid Policy & Health Systems Innovation; Medical Services Administration	Director
Murrell	Shelly	Michigan Department of Community Health, Workforce Transformation; Policy & Planning	Manager

Priest	Chris	Michigan Department of Community Health, Office of Strategic Policy	Senior Strategy Advisor
Prokop	Jackie	Michigan Department of Community Health, Program Policy Division; Medical Services Administration	Director
Sederburg	Keri	Michigan Department of Community Health, Office of Services to the Aging	Executive Director
Swisher	Ken	Michigan Department of Community Health, Employee Health Management	Director
Vanderstelt	Meghan	Michigan Department of Community Health, Office of Health Information Technology	Manager
Watt	Dana	Michigan Department of Community Health	Affiliate
Wycoff	Sara	Michigan Department of Community Health, Office of Strategic Policy	Strategy Advisor
Zeller	Lynda	Michigan Department of Community Health, Behavioral Health & Developmental Disability Administration	Senior Deputy

Appendix 3.2: Planning Team Members

Last Name	First Name	Organization	Title
Batdorf-Barnes	Ann	Population Health Partners, Professional Limited Liability Company	Principal
Blakeney	Scott	Michigan Department of Community Health, Health Planning & Org Support Division; Policy & Planning Administration	Director
Buege	Cindy	Michigan Public Health Institute, Center for Data Management and Translational Research	Electronic Medical Records Implementation Specialist
Callaghan	Carol	Michigan Department of Community Health, Chronic Disease/ Injury Control Division; Public Health Administration	Director
Coyle	Kelly	Michigan Public Health Institute, Innovative Solutions Team	Senior Analyst/Privacy Officer
Hertel	Elizabeth	Michigan Department of Community Health, Policy & Planning	Senior Asst.
Menzies	Amanda	Public Sector Consultants	Senior Consultant
Miles	Jeffrey	Michigan Public Health Institute, Center for Data Management and Translational Research	Project Coordinator
Moorehead	Melissa	Michigan Public Health Institute, Innovative Solutions Team	Senior Policy Analyst/ Project Manager II/ Business Analyst
Moran	Sue	Health Management Associates	Principal
Murrell	Shelly	Michigan Department of Community Health, Workforce Transformation; Policy & Planning	Manager
Powers	Jane	Public Sector Consultants	Vice President
Pratt	Peter	Public Sector Consultants	President
Riggs	Matthew	Michigan Public Health Institute, Center for Data Management and Translational Research	Research Associate
Rodgers	Tony	Health Management Associates	
Singhal	Nishi	Michigan Public Health Institute, Innovative Solutions Team	Business Analyst
Syrjamaki	John	Michigan Public Health Institute, Center for Data Management and Translational Research	Research Associate
Tanner	Clare	Michigan Public Health Institute, Center for Data Management and Translational Research	Program Director
Ward	Kristin	Michigan Public Health Institute, Center for Data Management and Translational Research	Research Assistant
Watt	Dana	Michigan Department of Community Health	Affiliate

Appendix 3.3: Advisory Committee Members

Last Name	First Name	Organization	Title
Ablan	Mary	Area Agencies on Aging Association of Michigan	Executive Director
Anderson	Todd	Blue Cross Blue Shield of Michigan	Director, Public Policy
Barnas	John	Michigan Center for Rural Health	Executive Director
Billi	Jack	University of Michigan	Professor, Internal Medicine and Medical Education, Medical School Associate Vice President, Medical Affairs
Blake	Rebecca J.	Michigan State Medical Society	Senior Director, Health Care Delivery, Physician Education and Foundation
Block	Wendy	Michigan Chamber of Commerce	Director, Health Policy and Human Resources
Bossard	Rick	University of Michigan Health System	Government Relations Officer
Brim	Melanie	Michigan Department of Community Health	Director of the Michigan State Innovation Model
Bupp	Cheryl	Michigan Association of Health Plans	Medicaid Policy Director
Canfield	Edward	Michigan Osteopathic Association	President
Cienki	Rebecca	Michigan Primary Care Association	Chief Operating Officer
Farmer	Andrew	Auto and Home Insurance Program of Michigan	Associate State Director
Fowler	Rob	Small Business Association of Michigan	President and Chief Executive Officer
Frush	Wendy	Mackinac Straits Health System	Chief Nursing Officer/Officer of Operations
Gauthier	Guy	Priority Health	Assistant Vice President, State Programs
Kohn-Parrott	Kate	Greater Detroit Area Health Council	President and Chief Executive Officer
Lockman	Stuart	Detroit Medical Center	President, MI Pioneer Accountable Care Organizations
Malouin	Jean	Faculty Group Practice at University of Michigan	Assistant Chair, Department of Family Medicine
Malouin	Rebecca	Michigan State University Institute for Health Policy	Director & Assistant Professor, Dept. of Family Medicine/Institute for Health Policy
Markzon	Caryl	Michigan State Medical Society	Chief, Physician Education
McKinley	Delaney	Michigan Manufacturers Association	Director, Human Resource Policy
Meadows	Phyllis D.	University of Michigan School of Public Health	Associate Dean for Practice
Mundt	Mary	Michigan State University College of	Dean and Professor

		Nursing	
Owen	Marion	Area Agencies on Aging Association of Michigan	Executive Director, Tri-County Office on Aging
Ponstein	Paul	Physician's Organization of Michigan Accountable Care Organization/ Michigan Center for Clinical System Improvement	Executive Medical Director/Chief Medical Officer
Reagan	Jane E.	Michigan Department of Education	Department Specialist, Office of Special Education
Reynolds	Lawrence	Mott Children's Health Center	President and Chief Executive Officer
Schonfeld	Peter J.	Michigan Health & Hospital Association	Senior Vice President, Policy & Data Services
Schultz	Amy	Allegiance Health	Director, Allegiance Prevention and Community Health; Medical Director, Jackson County Health Dept.
Sibilsky	Kim	Michigan Primary Care Association	Executive Director
Simmer	Tom	Blue Cross Blue Shield of Michigan	Senior Vice President & Chief Medical Officer
Sloan	Denise	Michigan Chapter American Academy of Pediatrics	Executive Director
Smith	Paul	Michigan Department of Human Services – Policy and Field Legal Services	Group Executive Policy Specialist
Studley	Richard	Michigan Chamber of Commerce	President and Chief Executive Officer
Sullivan	Ryan	Michigan Consumers for Healthcare	Policy Manager
VandenHeuvel	Rich	Lakeshore Regional Entity	Chief Executive Officer
VanGills	Linda	Michigan Association of Local Public Health	Health Officer, District Health Department #10
Vizena	Mike	Michigan Association of Community Mental Health Board	Executive Director
Wehrwein	Teresa	Michigan State University College of Nursing	Associate Dean for Academic and Clinical Affairs
Yaroch	Linda	Michigan Association of Local Public Health	Health Officer, Health Department of North West Michigan

Appendix 3.4: Advisory Committee Charter

PURPOSE

- The purpose of the State Innovation Model (SIM) Advisory Committee (hereafter the "Committee") is to work with the Governor's office – through the executive agency, Michigan Department of Community Health (MDCH) – to develop a State Health care Innovation Plan (SHIP). **The overall purpose of the SIM Project is**:

To develop a plan, with broad stakeholder participation, for a community integrated health system and a sustainable way to pay for it.

Refer to **Figure 1** for a high-level visual depiction of movement towards a community integrated health system. In Michigan, key elements of this plan will include:

- Increased accountability for specified outcomes that include per capita cost, quality, equity, and the health of Michigan residents
- Person and family-centered care that engages individuals in care that meets their needs and reflects their values
- Attention to development, health, and wellness over the lifespan of individuals
- Linkages between and among health care, behavioral health, public health, and community resources to address physical, behavioral and socioeconomic needs of the population
- An open and flexible model, creating a framework that supports integration and widespread adoption, and can be adapted within local communities
- Identification of critical success factors and promising practices drawn from the evolving body of knowledge on community integrated health systems
- A learning system at the state and local levels that promotes continuous quality improvement and dissemination of lessons learned in an agile framework
- A robust data system to drive strategic decision making
- Global policies, incentives, and penalties to drive implementation of a high-performance community integrated health system
- Aligned payment policies among multiple payers

SCOPE

- The scope of activities of Committee members shall include advising and making recommendations to the State Health care Innovation Management Team.
- This process is expected to be iterative and will require the Committee to be flexible in response to new information and ideas.

SUPPORT FOR THE ADVISORY COMMITTEE

- Each meeting of the Committee will be guided by an agenda, approved by the Management Team. All meeting summaries, reports, studies, and agendas will be made available on the project web site: https://public.mphi.org/sites/sim.

- MDCH-appointed staff, supported by the Michigan Public Health Institute (MPHI), Health Management Associates (HMA), and Public Sector Consultants (PSC), will be responsible for providing adequate support to the Committee. This will include: (1) notifying members of the time and place of each meeting; (2) providing relevant materials and assembling information; (3) maintaining summaries of all meetings and all outputs produced, including Workgroup meetings, and making these available to the Committee; and (4) facilitated discussion.

- All meetings of the Committee, including work groups (described below), will be led by a professional facilitator and will have an official recorder.

- Subject matter experts and analysts have been retained to provide information and reports that the Committee and work groups may request.

TIME EXPECTATIONS/MEETINGS

- The Committee will be convened for the duration of the "State Health care Innovation Model Design Grant," expected to run April - September 2013.

- The Committee will meet in person in the Lansing area approximately once per month and on occasion via phone or web conference. This schedule may be modified to achieve project goals.

REPORTS TO THE MANAGEMENT TEAM

- Committee recommendations will be submitted to the Management Team for incorporation into the SHIP.

- Facilitation of the Committee will be designed to achieve a high level of consensus on recommendations for the SHIP. It is unlikely, however, that all recommendations will be unanimous. Minority views/perspectives will also be shared with the management team.

WORKGROUPS

- The Committee may establish workgroups to focus on specific areas, as needed. Workgroups will aim for diversity of representation and will have specific objectives laid out by the Committee and Management Team.

- Individuals who are not members of the Committee, but who have expertise in a particular subject area, may be invited to participate in work groups.

- Workgroup outputs will be communicated to the Committee for consideration and deliberation.

Figure 1

Innovation Driven
US Health Care System Evolution

Health System Transformation Evolution Critical Path

Acute Health Care System 1.0

Non Integrated Acute Care

- Episodic Health Care
  - Sick care focus
  - Independent practice
  - High Use of Emergency Care
  - Multiple clinical records
  - Fragmentation of care

- Lack integrated care networks

- Lack of integration between acute and long-term care settings
- Lack quality & cost performance transparency

- Poorly Coordinated Chronic Care Management

Coordinated Seamless Health Care System 2.0

Outcome Accountable Care

- Patient/Person Centered
- Transparent Cost and Quality Performance
  - Results oriented
  - Assures Access to Care
  - Improves Patient Experience

- Accountable provider networks designed around the patient including LTC needs

- Shared Financial Risk

- HIT integrated

- Focus on care management and preventive care
  - Primary Care Medical Homes
  - Care management/ prevention focused
  - Shared Decision Making and Patient Self Management

Community Integrated Health Care System 3.0

Community Integrated Healthcare

- Patient, Population, and Community Centered
  - Community Health Resource Linked
  - Cost , Quality, and Population Health Outcome Transparency
  - Community Healthy Living Choices

- Community Health Integrated networks capable of addressing psycho social/economic and LTC needs
- Right care, at the right time in the right setting
- Population based reimbursement
- Learning Organization: capable of rapid deployment of best practices

- Community Health Integrated
  - Community Healthy Living Oriented
  - Community Health Capacity Builder
  - Community based support developer
  - Shared community health responsibility
- E-health and telehealth capable
  - Wide use of remote monitoring and telehealth and e-health management
  - Health E-Learning resources, social networking, health literacy tools

Produced by Health Management Associates

Appendix 3.5: Advisory Committee Meeting Summaries & Deliverables

SIM Advisory Committee Retreat: Summary

April 25, 2013

A. Michigan's Model Characteristics

Proposal:

The SIM Management Team has proposed seven characteristics of Michigan's future Community Integrated Health System:

1. Accountability
2. Person- and family-centered care
3. Community-centered design
4. Focus on prevention and wellness
5. System-wide linkages
6. Community-integrated systems
7. Evidence-based approaches.

The proposed process to develop Michigan's *State Health care Innovation Plan (SHIP)* is to:

- Validate the above articulated model characteristics
- Identify the "Innovation Challenge" (set performance or outcome goals for the system)
- Develop model design specifications
- Develop the model, including needed infrastructure, policy reform, payment model, and workforce implications
- Flesh out the model

Discussion:

The following points were made during discussion of the AC.

Payment Reform

- There is a need to include market reform as a model characteristic in order to align incentives with community health outcomes and a focus on wellness; Michigan has not been sufficiently aggressive on payment reform
- Incentives can potentially mean something broader than financial compensation
- The infrastructure to support PCMH and ACO models requires substantial up-front investment which requires compensation before incentive payments 'kick in'.
- Large funders, such as the Robert Wood Johnson Foundation have noted a lack of progress on payment reform in Michigan.

Patient Engagement

- Patient centeredness should include concepts of patient accountability for health behavior
- Patient engagement around health behavior and decision-making is required.

Recommended Refinements to the Characteristics:
- ✓ The concept of paying for value will be added as a model characteristic
- ✓ The concepts of patient engagement and accountability will be addressed under existing model characteristics

B. Panel Discussion: Michigan's Innovation Foundation

Panelists:

Jean Malouin, MD, MPH: Associate Chair for Clinical Programs in Family Medicine, Associate Medical Director for UM Faculty Group Practice, Medical Director and Co-Project Lead for Michigan Primary Care Transformation (MiPCT), part-time Medical Director for BCBSM Value Partnerships Group

Paul D. Ponstein, DO: Executive Medical Director for Physician's Organization of Michigan ACO, CMO of Michigan Center for Clinical System Improvement, Steering Committee member for both MiPCT and CMMI COMPASS grant

Amy Schultz, MD, MPH: Director of Allegiance Health Department of Prevention and Community Health, Medical Director for Jackson County Health Department

Rich VandenHeuvel, MSW: Executive Director of West Michigan Community Mental Health System, Chairperson of Michigan Association of Community Mental Health Boards (MACMHB) Health care Reform Technical Workgroup, the MACMHB Policy Committee, and the MACMHB Western Region, member of the MACMHB Executive Board

Themes:

Panelists representing many different sectors of health care – some of whom were unfamiliar with each other's' work – nevertheless highlighted some common themes.

Difficulty in balancing prevention and sick care
Program mandates and incentives often emphasize serving the sickest, most complex populations, making it difficult to promote wellness and prevent declines in health status and functioning

- While MiPCT [the Michigan Primary Care Transformation project] hopes to achieve budget neutrality in three years by providing complex care management to prevent unnecessary hospitalizations and ED visits, it still focusses on managing the health of the entire population, utilizing care managers to prevent healthy patients from becoming sicker and requiring more active complex care management.
- CMHSPs [Community Mental Health Service Programs] are charged to serve the severely and persistently mentally ill, children with serious emotional disturbance, and persons with developmental disabilities. Nevertheless, some are making investments into co-locating service providers with PCPs in order to provide behavioral health services to those who are less severely impaired

Importance of Linkages and Community Integration
- MiPCT recognizes the importance of assisting patients to navigate the "Medical Neighborhood"
- There are cultural differences across service settings: relationships must be enhanced at a practitioner-to-practitioner or bureaucrat-to-bureaucrat level

- Patients may spend 15 minutes with a health care provider, followed by 6 months of living in the community: health outcomes and health care costs cannot be addressed inside the "bricks and mortar of the health care delivery system" alone.
- While providers are beginning to be held accountable for changing patients' health behaviors, they must be supported by community-level interventions
- ACOs and PCMHs are discovering that high-cost, high-risk patients may require much more intervention to address mental health and social determinants in addition to clinical care
- CMHSPs are resources in the community that already have skills in patient engagement and motivational interviewing – these existing resources in the community should be tapped to support community-integration efforts
- The Collective Impact Model highlights the importance of:
  o Alignment of funding priorities across the health and community systems (e.g., including the United Way)
  o Formal integration of services through shared staffing
  o Leveraging public will through neighborhood level activation
  o Infrastructure to support all of the above

Payment Models, Metrics and Accountability

- MiPCT performance incentives are focused on process and outcome measures and reducing unnecessary spending
- ACOs cannot earn shared savings if they do not perform well on 33 quality metrics. ACO performance on the metrics will be publicly shared
- The Collective Impact Model incorporates a shared community action plan with shared community-wide metrics to track progress; outreach to payers to incorporate these community-wide metrics is underway (but challenging)
- The commitment to evidence-based practices should be framed in terms of "learning our way forward through evolving evidence," so that when there isn't extant evidence we can still make progress

C. Michigan's Innovation Challenge

Proposal:

The SIM Management Team proposes six goal statements to form the basis of the SHIP. These statements, also called the "Innovation Challenge" will guide further work by the AC to specify a future service delivery model for Michigan. The AC was asked to consider whether it endorses these goals, whether one or more goals could be eliminated, or whether additional goals should be articulated.

Discussion:
I. *Strengthen the primary care infrastructure to expand access for Michigan residents.*
   - Leverage existing primary care infrastructure and investments in PCMH
   - Workforce development, community capacity, and scope of practice may need to be addressed to achieve this goal; explore using primary care rotations before residency
   - The ACA only addresses access to insurance. We must understand other reasons that people are not connected to primary care
   - We need a culturally competent workforce to ensure that consumers are comfortable and feel that their needs can be met.
II. *Provide care coordination to promote positive health and health care outcomes for individuals requiring intensive support services.*

- As with goal one, leverage existing resources that are working well
- Care coordination is integral to health care systems of the future
- Care Managers cannot achieve coordinated care without systems and infrastructure changes:
  - Health information systems must support population health management, including: registries and data exchange such as Admission/Discharge/Transfer (ADT) notifications
  - Additional work on communication across settings and linkages to community services
  - Support of the health plans and payment for care coordination activity

III. ***Build capacity within communities to improve population health.***
- Local public health is a resource
- Payment models should recognize the role of public health and include investment in community infrastructure
- Businesses/employers are a resource in terms of benefit design and community health investments
- This goal requires an operational definition of "community"

IV. ***Improve systems of care to ensure delivery of the right care, by the right provider, at the right time, and at the right place***.
- Achieving this goal requires attention to:
  - The nature of the Care Team, including the role of Care Managers, and community-based navigation support
  - Use of Tele-health
  - Patient engagement and accountability
  - Accountability of pharmaceutical companies for their messaging
  - End of life care
- Examine the potential role of Tort reform

V. ***Design system improvements to reduce administrative complexity.***
- The emphasis on making data-driven decisions conflicts with this goal. Requirements for collecting and reporting data contributes to administrative complexity.
- Perhaps, together, these goals point to a "universal language for health care" through which all parties have access to the information they need.
- Common standards for health information would help

VI. ***Design system improvements that keep insurance premiums affordable for individuals/families and employers/businesses.***
- The experience of Massachusetts reveals that addressing cost containment is critical to the goal of increasing access
- It is important to address the relationship between per capita health care costs and health insurance premiums here.
- The role of the Insurance Commissioner may be important to achieving this goal

Recommended Refinements to the Innovation Challenge:
- ✓ Each goal was affirmed as important,
- ✓ The importance of paying for value was a common theme
- ✓ Achieving these goals requires attention to HIT and data infrastructure
- ✓ Alignment and efficient use of human and community resources will be important

✓ The phrase "reduce health care costs" will be added to the last goal

D. Next Steps

The next meeting will be May 23, 1-4 in the Lansing area, additional details forthcoming.

Appendix 3.5 (Cont.): May 23, 2013 Advisory Committee Meeting Deliverable

MICHIGAN'S HEALTH CARE INNOVATION MODEL DESIGN SPECIFICATIONS

Michigan's SIM stakeholders recommend that future service delivery models have the following characteristics: Accountability; Person- and Family-Centeredness; Community-Centeredness; Focus on Prevention, Wellness, and Development; System-Wide Linkages; Community-Integration; Evidence-based; and Payment for Value in order to achieve the goals below.

Goals

Goal I.   Strengthen the primary care infrastructure to expand access for Michigan residents.

Goal II.   Provide care coordination to promote positive health and health care outcomes for individuals requiring intensive support services.

Goal III. Build capacity within communities to improve population health.

Goal IV.   Improve systems of care to ensure delivery of the right care, by the right provider, at the right time, and at the right place.

Goal V.   Design system improvements to reduce administrative complexity.

Goal VI.   Design system improvements that contain health care costs and keep insurance premiums affordable for individuals/families and employers/business.

Model Characteristic: Accountability

- Accountability and responsibility are intertwined concepts
    a. Responsibility is internalized, and is a prospective acknowledgement of one's role in an outcome
    b. Accountability may be imposed, and is retrospective based on results
- The following partners share accountability in a community integrated health system that is aligned with the Goals and Model Specifications of the State Innovation Model for Michigan
    a. Individuals/patients, families, community members, civic groups
    b. Payers
    c. Providers, including primary care, specialists, behavioral health care, education and child welfare, human services
    d. Organizations, including ACOs and Physician Organizations
    e. Hospitals, health care delivery systems, and other facilities
    f. State and local public health
    g. Government: housing, community planning, transportation, schools
    h. Community service agencies/organizations
    i. Businesses and employers
- These partners are accountable for:
    a. Working together across sectors to integrate clinical, behavioral, and social care with public health and community resources
    b. Collaborating to create a community integrated health system that delivers better population health and better care, at a lower cost
        i. "Population" is defined in terms of, 1) geographical boundaries and/or, 2) a subset of at-risk individuals
        ii. "Health" is defined in broad terms including physical, behavioral, and dental

- c. Creating learning systems that continually improve the health system
- d. Assuring access to social services, behavioral/mental health services, and physical health care and health services
- e. Assuring equity in the health system, demonstrated by the lack of racial/ethnic/geographic health disparities
- f. Aligning their processes with Michigan's desired model characteristics, including: accountability, person- and family-centeredness, community-centeredness, prevention/wellness/development focus, system-wide linkages, community integration, evidence-based, and payment for value
- Systems of accountability include:
    - a. Clearly specified roles and responsibilities delineating who is accountable for health and health care needs in order to reduce service duplication
    - b. Availability of effectiveness and cost information for providers, policymakers, and patients/community members for individual clinical and population-level decision-making
    - c. Comparative outcomes monitoring and performance feedback
    - ➢ Suggestions for accomplishing this include:
        - A interoperable health information system that addresses outcomes, quality and cost across the life course, including point in time and across time
- Measures of accountability are:
    - a. Prioritized to reflect goals defined by the community
    - b. Relevant to the population served
    - c. Evidence-based
    - d. Manageable in number and reporting burden
    - e. Transparent and available for decision-making
    - f. Common across payers
    - g. Sensitive to the limits of available knowledge and technology to achieve the desired outcome
    - h. Available to all accountable entities (including individuals/patients)
    - i. Fair according to what the accountable entity can reasonably achieve
- The legal system, as a mechanism to ensure accountability, does not place undue risk on patients or providers, or promote defensive medicine
    - ➢ Suggestions for accomplishing this include:
        - Practices adhere to evidence-based interventions to reduce liability concerns of defensive medicine
        - Standards of liability are based on an objective analysis of data, rather than subjectively on harm done
        - Malpractice claims are settled outside of the court system through arbitration or a no-fault system
        - The state pays liability claims, at least for Medicaid providers who meet quality parameter

Model Characteristic: Person and Family-Centeredness

- Individuals have access to primary care as defined by the Institute of Medicine: "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[1]
    - a. The source of primary care may vary by the health needs of the individual
    - b. Family is defined broadly by the patient, not restrictively

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[1] Donaldson MS, Yordy KD, Lohr KN, Vanselow NA (Eds.). (1996). *Primary Care: America's Health in a New Era*. National Academies Press. Retrieved from http://www.nap.edu/catalog.php?record_id=5152.

- Community partners support and incorporate the principles of person- and family-centered care (PFCC) across the health system
- Access to care is maximized, especially for underserved and/or vulnerable populations through appropriate and effective methods that may include:
    a. Services located in areas where at-risk individuals with high need reside
    b. Settings where people naturally congregate – potentially in-home for some populations
    c. After-hours or urgent care options linked to primary care with shared patient records
    d. Telemedicine
- The relationship between providers and patients is mutually respectful and emphasizes informed, shared decision making, characterized by:
    a. Attention to health literacy, and the needs, values, experience and wishes of the 'whole person'
    b. Continuity of care
    c. Person-centered care plans
    d. Use of methods and tools such as self-management support, motivational interviewing, plain language communications, and culturally appropriate materials and communication techniques (such as instant messaging, social media, and personal health records)
    e. Provision of social and structural support to patients to improve their health
- Community partners address root causes of poor health and they recognize the multiple determinants of health, including genetics, medical care, social/racial/cultural, economics, environmental factors, and lifestyle/ behavioral
- A community has standardized and clear information for patients on common conditions that is sensitive to language, cultural, and literacy norms in the community at a wide variety of venues
- Eligibility and payment processes are simplified
    - Suggestions for accomplishing this include:
        - Consolidating information regarding covered benefits for the Medicaid and Medicare eligible population
        - Providing family members the option to be covered by a single plan and served by a common primary care provider
        - Determination of eligibility not more than once per year
        - Basing eligibility for public services on need rather than category
- Emerging technology supports patient- and family-centeredness by enabling efficient, standards-based health information exchange to support care coordination
    - Suggestions for accomplishing this include:
        - Consolidation of patient records (into a single care plan or confidential personal health record, for example)
        - Online access to information and forms

Model Characteristic: Community-Centeredness

- Consumers are organized so that they become engaged/mobilized to influence health outcomes
- Communities define priorities and the measures they are evaluated on

- Collaborative leadership exists across the community that is responsible and accountable for shared outcomes, quality, and cost

- All public policy is examined for impact on community health, with input from the affected community

- Community input is considered essential in identifying the health issues of a community through local assessments, (such as a Community Health Needs Assessment)
- Patients/individuals are represented on health system boards, committees, coalitions, and councils so that their perspectives influence policy and health system design
- Preventive and developmental services are tailored to the needs of the community
- Providers understand their communities (and know population health data) and use this understanding in caring for patients and the community
- Community rated insurance premiums identify specific community factors affecting medical cost risk
- Health plans, health systems, providers, employers, and community leaders collaborate to lower risk factors in high risk communities
- Researchers take a participatory research approach

Model Characteristic: Prevention, Wellness, Development

I. Health and well-being are addressed in clinical encounters *and* in the community
   a. Individuals receive all age appropriate, condition appropriate, and evidence-based primary and secondary preventive care
   b. Services may be provided by non-physicians
   c. Evidence-based behavioral health interventions are used when appropriate
   d. Prevention and wellness services are tailored to community needs and culture
II. The Life Course model guides the actions of community partners
   a. There is a focus on child health to set a healthy trajectory for life beginning with preconception
   b. All individuals are viewed on a continuum of wellness, and providers work to optimize functional status for all patients
   c. The cumulative impact of social determinants and life stressors across the life course is incorporated
III. Technology is interoperable and supports health management and wellness promotion
   ➤ Suggestions for accomplishing this include:
     - Integration and tracking of information on preventive services received
     - Effective use of health information technology (HIT) to assure consistency of clinical prevention, public health, and population-level data, forms, and services
     - Data standards are developed and disseminated that promote interoperability
     - Rapid deployment and ready access to innovative tools that promote health and wellness
IV. Community stakeholders (individuals, businesses, organizations, government agencies, payers, providers and others) share in investments that raise community health status in the long-term, including:
   a. Supporting healthy lifestyles (such as safe places to exercise and availability of healthy food)
   b. Addressing social determinants that impact health and costs of care (including violence, drugs, child development, and at-risk youth)

Model Characteristic: System-wide Linkages

I. Primary care teams assure that patients receive comprehensive and coordinated care within a well-designed, high-performance system of care that can reliably provide all of the preventive, acute and chronic care services needed by the individual, and is intentionally designed to coordinate care across the health care delivery system, including specialty care, urgent care, hospitals, home health care, oral health providers, and link the individual to community services/supports

II.   Public health care teams are responsible for linking patients to an integrated system of care that is designed to coordinate care reliably and consistently across the health system, and link the individual to community services/supports and public health

III.   Local public health is a key partner in linking the primary care with public health services and other community resources, and provides a connective thread across integrated systems of care

IV.   Linkages across the health and community systems connect at-risk individuals to medical and social services and ensure:

 a.   Identifiable 'entry points' to community services using a no wrong door approach

 b.   A closed loop referral system with shared responsibility across community stakeholders

 c.   Seamless integration of prevention and developmental services, programs, and policy across sectors (schools, health care, places of worship, public health, worksites)

 d.   Integration of behavioral health, oral health, nutrition and physical activity, and social determinants of health

➢ Suggestions for accomplishing this include:

• Advocacy to ensure the availability of support systems to assist patients/consumers in accessing services

• Sharing information about available resources through regular, face-to-face communication

V.   Community health workers are involved in communicating with patients and prospective patients in order to convey information and connect people to the right care

VI.   Care coordinators assist with navigation and coordination, promoting smooth transitions between care settings for individuals needing intensive support services

VII.   Coordinated care is supported with meaningful HIT that enhances (rather than impedes) provider workflows, promotes information exchange across health and social service sectors, and assures confidentiality using simple and consistent privacy rules

➢ Suggestions for accomplishing this include:

• Use HIT to develop a common Personal Health Record or linkage of patient records

Model Characteristic: Community Integration

1)   A statewide model for a community-integrated system is developed to provide a consistent standard of care, that meets the unique needs of community residents, and includes the following:

 a.   Community partners take a health in all policies approach using evidence-based models

 b.   Cross-sector partnerships work together for collective impact with common goals and measures

 c.   Common working knowledge, including shared definitions and terminology across disciplines and systems

 d.   A backbone organization supports this work

 e.   Representation of providers and patients/individuals on health system boards, committees, coalitions, and councils so that their perspectives influence policy and health system design

 f.   The identification and development of leaders within the community to promote initiatives that will improve the community's health

 g.   Clearly defined roles and responsibilities for all partners in the system

 h.   Stakeholders are educated in the goals of health equity as well as delivery of the right care, by the right provider, at the right time, and at the right place

 i.   Consistent educational materials and messages in support of community health goals

 j.   Collaborative capital investments in standardized data systems

       k. Community health data collection, analysis and dissemination (including needs assessments, and potentially community surveys)

2) A statewide model for a community-integrated health system takes a bottom-up, top-enabled approach, which supports local systems of care to achieve improved health and health care at lower cost and in manner that is tailored to the needs and priorities of the community, while providing a consistent standard of care with the following components:

       a. A regulatory framework (e.g., shared data, common measures, and supportive policies and payment mechanisms)

       b. A learning system for continuous improvement which includes
          i. access to population level data for improving individual and population level outcomes
          ii. sharing best practices and lessons learned

       c. Common language and definitions

       d. Shared resources and support infrastructure

3) Public health has a leadership role in forming health policy and is fully integrated with other local community services

       a. Public health supports primary care services and is part of an accountable health system

       b. De-identified, aggregated public health data, and de-identified, aggregated clinical data are available for understanding population health trends; clinical data are available at the point of care and access is limited to those practitioners involved in the patient's care as directed by the primary care team in partnership with the patient

4) The socio-ecologic model guides actions of the community partners at the individual, organization, community, and policy levels

5) A community integrated health system has an entity (or multiple entities) which acts at the local level, accepting responsibility for the integrator functions necessary to achieve outcomes of better health, health care and cost containment

Model Characteristic: Evidence-based

  I. Providers and community partners integrate evolving research evidence, practitioner expertise, and the characteristics, preferences, needs, and values of the community and patient/individual in order to deliver the right care, by the right provider, at the right time, and at the right place

  II. Comparative effectiveness information is available and shared between provider and patients when discussing treatment options

  III. Best practices and critical success factors are shared to build a body of knowledge that community partners recognize for provider and patient decision-making, planning preventive services and population level interventions, and for organizing and mobilizing the community

       a. Accepted standards and practices quickly adapt to emerging evidence

       b. Both clinical and transaction data and information are collected, tracked, and analyzed to determine evidence-based practices for the right care, by the right provider, at the right time, and at the right place

       c. Outcome data on effectiveness and cost are shared across systems in a timely manner with providers and patients/individuals for use in decision-making

       d. Support is provided for primary care process redesign and implementation of electronic records

  IV. Community partners and health care providers are committed to continuous improvement and learning together over time

Payment for Value

I. Payment models incentivize desired processes and outcomes, including:

    a. Defined clinical and community-based measures of value that are achievable with available resources

    b. Right care by the right provider, at the right time, and at the right place

    c. Recruitment and retention of primary care providers

    d. Patient engagement in care

    e. Long-term continuity of the patient-provider relationship

    f. Long-term risk reduction and health status improvement

    g. Coordination of care across the health care delivery system, social service agencies, and community resources

    h. Health information exchange assures appropriate access to confidential data/information that is current and relevant for making decisions for (and with) individuals and populations

    i. Service delivery in underserved areas

II. Payment is sufficient and provided in such a way as to encourage the best use of resources – including wellness care, or visits that occur with health care team members other than a 'billable' provider

III. The value of public health is clearly recognized by the entire community

IV. There is full reliable funding for public health services

V. Health equity and access considerations guide community partners in proper distribution of resources

VI. Alignment across payers and programs is maximized

VII. Payment models and incentive metrics are analyzed to ensure there are no unintended consequences and that all incentives encourage processes that are linked to positive outcomes

VIII. Payment metrics take into account increasing clinical complexity, and other patient factors, that may affect whether treatment guidelines are appropriate

IX. Community partners work together to identify sustainable financing mechanisms for:

    a. Non-medical services that add value (such as community health workers, behavioral health, social services)

    b. Population level interventions (to address social determinants of health, built environment, community development)

X. Payers reward *community performance* (with measures that are relevant to the community)

XI. Assistance is available to help providers adopt technology that would reduce administrative complexity, improve care, and take on increased responsibility for outcomes

    ➢ Suggestions for accomplishing this include:

        • Provision of low-interest loans

XII. As part of health benefit premium pricing for both employers and individuals, there are incentives that appropriately balance risk and rewards that encourage use of evidence-based, cost effective treatment options, use of generic drugs, self-care management, and use of wellness programs and healthy living

    a. Pricing, co-pays, and deductibles are transparent and understandable to patients

    b. Smart benefit features reward long-term maintenance of the same health plan and achievement of wellness goals

XIII. Provider payments include a warranty period for treatment or procedures performed by a provider

Appendix 3.5 (Cont.): June 26, 2013 Advisory Committee Meeting Deliverable

ADVISORY COMMITTEE MEETING SUMMARY

The Advisory Committee was held June 26th, 2013. This document is a summary of the comments and suggestions offered by the participants on the key elements of Primary Care, Systems of Care, and Community Capacity that should be included in the service delivery model.

Primary Care

What are the key elements that should be part of the Michigan model?

- The goal ought to be strengthening primary care infrastructure AND improving access. As it is currently worded, the focus is primarily on improving access. We should focus on improving quality of care and outcomes.

- We may be limiting ourselves by focusing on Patient-Centered Medical Home (PCMH) rather than Patient-Centered Health Home (PCHH), i.e. losing our focus on community integration and remaining overly clinical, however primary care physicians have invested and continue to invest significant effort and time in PCMH and probably cannot take on anything broader. The promise of additional income from PCMH designation has not materialized for many primary care physicians.

- We need to build on the assets we already have, i.e. integrating behavioral health and human services better could take some burden off of primary care. As it stands, providers are accountable for linkages with no reciprocal accountability assigned to community partners.

- Taking a team-based approach can spread costs more sustainably, as well as lighten the medical burden on primary care by promoting wellness.

- Primary care providers can be supported in understanding the broader health care 'ecology' of the community by having public health as a full partner for community monitoring and engagement to address equity and disparities.

- Increase the number of primary care providers and proportion of physicians in primary care in addition to providing better infrastructure supports.

- Person-centeredness needs to be a cross-cutting theme, e.g. when thinking about PCMH/PCHH and issues of attribution, assignment, and the control thereof, we need to be cognizant that it is the patient's 'home' we are referring to. So, we need to better define whether person-centeredness is simply a founding philosophy or an operational guideline.

- Different levels of medical/health home a possibility depending on needs of target populations – don't need a one-size-fits-all approach

Are there priorities among gaps? Which ones should we address first?

- Community linkages and behavioral health are integral to PCMH; we just have not done as well as we could yet with those aspects in existing PCMHs. However, PCMHs are still being tested. Michigan is leading the nation in PCMH Physician Group Incentive Program (PGIP) certification at about 1,250.

- Access and expansion are priorities, and while Medicaid managed care beneficiaries all have a primary care provider on paper, transportation is a major barrier for some.

- We need to be frank among ourselves about the limitations of significant portions of the population (this may be even higher among high-utilizers) in their ability to navigate the health care system due to low literacy, which is not improving over time. We need to make sure that we have the tools for engaging consumers that they can use.

- One issue with PCMH is the incentive for physicians to increase rates (for doing what they were supposed to do) which increases the cost barrier for the uninsured, since physicians can't charge different people differently. Federally Qualified Health Centers (FQHCs) use sliding scales based on income to address this issue while charging people the same rates.

- Many health home models fail to address the life course, and leave questions as to who sets the outcomes for which the home is accountable.

- The majority of participants agreed that the characteristics and specifications related to PCMH that were the focal point of the discussion were acceptable, but that the terminology needed to be better defined.

Systems of Care

Do people agree with a multi-payer ACO?

- Accountable Care Organizations (ACOs) face population management difficulties among mobile populations like college students, 'snowbirds,' and others who travel frequently. This could require arrangements such as multi-state ACOs, or reciprocal relationships between ACOs in different states. Physicians can only be accountable for what they can actually manage, but patients are also likely to realize the value of having coordinated care.

- We need to define what multi-payer means in this context; how does Medicaid Managed Care fit in?

- We should clarify whether a multi-payer model includes global budgeting, and at what scale a global budgeting framework could achieve efficiencies.

- Multi-payer means that different payers can look at how to achieve behavioral changes in the system through individual payment strategies, but for common goals, through interoperable systems, and common network foundations. Massachusetts is accomplishing this with a global budget/payment strategy that everyone must use, or pay a tax to go somewhere else.

- Can we expand the ACO concept beyond commercial, beyond Medicare/Medicaid, beyond Health Maintenance Organizations (HMOs), and include special population ACOs?

- ACOs can include all aspects of the community of care and integrated care.

- There is a lot being done with shared savings models and financial tests are underway, as well as the Organized Systems of Care (OSC) approach from Blue Cross Blue Shield of Michigan (BCBSM), that should be addressed or incorporated in the model.

- Genesee County's Pioneer ACO may not exist a year or two from now; the sustainability of the extant model is questionable. We need a continuity plan for funding these efforts. There's no commitment to building real infrastructure and sustainable organizations.

- We have to be a lot more definite about what we mean by ACO-. The startup and maintenance costs are a probable barrier, and mobility of the population makes attribution difficult. Too many different models exist out there. Everyone is doing something different.

- "ACO" has a legal definition per the U.S. Department of Justice and the Federal Trade Commission: For contracting, all participants must be clinically integrated, financially integrated for equitable incentive distribution, and the ACO can have no more than 33% market share before it loses some safe harbors. Evidence of clinical integration includes common electronic health record (EHR) infrastructure, common clinical procedures, common governance, etc. Does Michigan want to adopt this formal definition or just focus on accountability networks?

- Regarding ACO formation in HMO states: whatever the organizational convention is for assigning patients in states with managed care, the managed care organizations are facilitating that in ACO development. In states where it isn't mature, the State takes the lead.

- We need to support accountable care but do so in a way that engenders the right care at the right time and right setting, and does not restrict patients to a silo of care as might happen in an ACO.

- Who is included in an accountable or integrated care organization? Is it only medical, or does it include public health and social services? Will being part of an ACO be mandated?

Participants in the room agreed generally that further exploration and development of the idea of an ACO should be included in the design of state model for an integrated system. Some participants suggested they want statewide-integrated system initiatives and a set of definitions. Participants also want to hear about proposed solutions for the challenges that have been identified. Many participants stressed that we need to leverage what is in place in Michigan.

Community Capacity

What are the key elements of effective cross-sectoral partnerships?

- Key elements for successful community partnerships are inclusivity of all impacted groups, and among those groups: a common agenda, common goals, mutually reinforcing activities, continuous communication, and a backbone organization infrastructure.

- Genesee County has a 15-year old collaborative effort (Greater Flint Health Coalition), which is a neutral convener within a defined geographic area. The partners in the coalition have spent significant time working together. Establishing relationships is important to strong partnerships.

- When time is not available for relationships to evolve, contracts can be useful to establish roles and responsibilities among partners.

- There are examples of payers, such as Priority Health, who are funding social benefits and prevention efforts focused on wellness.

- We are currently missing elements such as representation from consumer groups, not only patients, but also disease-specific organizations, such as the Kidney Foundation, Cancer Society.

- There are huge differences in community capacity across geographies in the state that will require a strategic plan to address.

- To support communities and create partnerships, stakeholders need to develop and ratify a common set of data elements and data collection protocols/processes to look at evidence.

What do key stakeholders need to do to support the key elements?

- We need to get serious and focused on where and for whom the system isn't working. It will take everyone to identify these gaps.

- Can this group come up with a core set of capabilities that each community should have in place, and fund communities trying to accomplish/demonstrate those capabilities/goals? Would the state establish these competencies, or the SIM AC?

- Stakeholders need to fund the infrastructure building that the community has identified as necessary.

- We need to establish what local groups need to do to make sure that upstream needs are met and funded.

- The Fetal Infant Mortality Review (FIMR) process is a model that could potentially be adapted for a locally responsive approach to addressing gaps/disparities.

- We need to give local primary care providers a list of local resources and contact information, so they know how to connect their patients to these resources.

- Stakeholders have to keep educating legislators and policy makers repeatedly about community assets and resources due to term-limits and turnover.

- We should focus regionally, not statewide. This planning effort should result in a regional pilot.

Appendix 3.5 (Cont.): July 16, 2013 Advisory Committee Meeting Deliverable

MICHIGAN STATE INNOVATION MODEL (SIM) WORKING CONCEPT

Michigan's multi-stakeholder State Innovation Model (SIM) Advisory Committee has met on four occasions to define the goals, characteristics, specifications, and component elements of a Community-integrated Health System for Michigan. (Hereafter, this document will utilize the grant name, "SIM" to refer to Michigan's working concept for a Community-integrated Health System.) The goals and model characteristics specified by the Advisory Committee are listed in Appendix A. Additionally, the Michigan Department of Community Health has identified a number of strategic priorities that are in line with stakeholder input, including: 1) improving population health, 2) transforming systems of care, 3) reforming health care, and 4) transforming the Michigan Department of Community Health.

This document lays out elements of an innovative delivery system that:
1) Recognizes that achieving results of better care, better health and lower cost are essential goals as coverage expansion, an aging population, and an epidemic of chronic disease will increase demand for care
2) Enhances infrastructure for health system transformation, information exchange, ongoing outcomes measurement, and quality improvement
3) Builds sustainable infrastructure that provides a platform for future health system transformation
4) Draws on and seeks to align elements of the existing health care delivery system and population level initiatives in Michigan
5) Aims for multi-payer alignment to leverage investment, align payment, and reduce administrative complexity
6) Incorporates stakeholder guidance as articulated by the SIM Advisory Committee
7) Advances the strategic vision of Governor Rick Snyder and the Michigan Department of Community Health for:

Michiganders to be healthy, productive individuals, living in communities that support health and wellness, with ready access to an affordable, patient-centered and community-based system of care.

Model Elements

The primary model components (those with responsibility and accountability for ensuring key processes and outcomes are met in Michigan's SIM) include: Patient-Centered Medical Homes; Accountable Systems of Care; Community Health Innovation Regions; payers; and state and local infrastructure supporting health information exchange, data analytics, outcomes monitoring, performance transparency, continuous improvement, and health care transformation. Most importantly, Michigan's SIM recognizes the role of person-centeredness and personal responsibility for health and wellness. The model incorporates evidence-based self-management support and patient engagement strategies to assist patients with low health literacy and barriers in the form of social determinants of health. In addition, the model incorporates evidence-based, population-level strategies that foster the conditions within which individuals can make healthy choices.

Patient Centered Medical Home

Patient Centered Medical Homes are the foundation of integrated health care delivery that provides better access and better care in the Michigan SIM. The Patient Centered Medical Home is a model of primary care practice in which proactive management of a defined population is: 1) patient/person- and family-centered, 2) linked to the broader health system and community services, 3) responsive to the large majority of each patient's physical and mental health care needs, 4) focused on prevention, early intervention, and wellness, 5) effective in managing acute care episodes and complex chronic conditions, 6) accessible with expanded practice hours and innovative communication technologies. The Patient Centered Medical Home utilizes alternative patient communication strategies, and assures around-the-clock telephone or electronic availability of a knowledgeable clinical decision-maker. The Patient Centered Medical Home employs an organized and systematic approach to quality and safety, utilizing evidence-based clinical practice guidelines and data analytic and decision support tools to effectively manage individual patients while contributing to the overall population health outcomes.

Michigan's experience with Patient Centered Medical Home and primary care has taught the following lessons that the SIM will address:

- While Patient Centered Medical Homes have lead responsibility for coordination of care for their patients, they cannot be held solely responsible for successful care coordination. Patient Centered Medical Homes require participation and cooperation from other entities within the health care and community service systems in the care coordination process.
- Becoming a Patient Centered Medical Home is challenging and requires resources and investments in information technology, practice coaching and process design, training, administrative support, and allocating and sharing resources across practices. For Patient Centered Medical Homes to achieve optimal health care outcomes, they must be supported by a health care network that assists with practice transformation, facilitates the exchange of relevant health information, and provides resources and the necessary technology infrastructure for care coordination and management. The Patient Centered Medical Home must also be supported by a community in which healthy choices are easy choices.
- To maximize primary care access for the underserved the following strategies are utilized:
    a. Delivering care in the right place, such as: in neighborhoods, community centers, schools, and shelters
    b. Offering 'enabling services' (part of the delivery model of a Federally Qualified Health Center) such as translation, transportation, case management, and health education
- To reduce workload on the primary care provider and enhance outcomes, other professionals augment the Patient Centered Medical Home to address:

Michigan Department of Community Health 2013 Strategic Priorities:

I. Support the person-centered medical home model and preserve the safety net

II. Integrate services for physical health and mental health and increase coordination among care providers

III. Develop opportunities for persons with mental illness and substance abuse issues to receive early intervention services

IV. Enhance efforts to identify and improve early intervention mental health services for children and youth

V. Create an integrated multidisciplinary delivery system with a focus on person-centered models of care

VI. Enhance technical support for Federally Qualified Health Centers

a. Social determinants of health
b. Behavioral health care needs, including early intervention and referral to substance abuse treatment, managing care and treatment of mild to moderate mental illness, and children's behavioral care

In order to strengthen primary care capacity and capabilities, and increase recruitment and retention of primary care providers, we must support and invest in existing Patient Centered Medical Homes, encourage transformation of additional primary care practices to become Patient Centered Medical Homes, and expand our primary care workforce. Michigan's SIM incorporates the following strategies:

- Evolving <u>Health Homes</u> as extensions of Patient Centered Medical Homes that integrate primary care with behavioral health and community services for vulnerable, high-risk individuals with complex needs. Health Homes may be developed specifically as <u>Behavioral Health Homes</u> for individuals with serious and persistent mental health conditions; or as inter-professional <u>Community Health Teams</u>.
- Expanding <u>Pathways Community HUBs</u> which target vulnerable and high needs populations. HUBs utilize community health workers who serve as navigators to appropriate services and resources and engage patients to address their health needs through home visits and ongoing follow-up.
- Developing <u>Accountable Systems of Care</u> that provide support to Patient Centered Medical Homes and are described in additional detail below.

Accountable Systems of Care

The Accountable System of Care is a formal entity that integrates and supports a network of providers and services that proactively manage coordinated, comprehensive care for a defined population. Accountable Systems of Care are accountable for improving quality and patient care experience while lowering costs for a defined population. To reduce administrative complexity the Michigan SIM provides strategies for multi-payer alignment across outcome measurement standards, reporting processes, and other requirements.

SIM recognizes that the Michigan Department of Community Health is committed to utilizing private managed care entities as delegated payers for Medicaid beneficiaries to enhance quality of care and contain costs. The Accountable Systems of Care are organized networks through which the managed care entities delegate, manage, and share performance outcome risk and financial rewards with providers.

The Accountable Systems of Care are likely to develop out of existing health systems, provider networks, Physician Organizations/Physician Hospital Organizations, qualified health plans, Medicare Accountable Care Organizations, Organized Systems of Care, and networks of safety-net providers. The Accountable System of Care will establish formal networks through contracts with the following entities:

- Patient Centered Medical Homes, Health Homes, and other Safety-net Providers

Michigan Department of Community Health 2013 Strategic Priorities:

VII.   Establish a strategy for improving the continuum from preconception to early childhood

VIII. Establish and support policies for a full continuum of services for Long-term Care

IX.   Identify and target chronic care hot spots

X.   Implement Michigan Health and Wellness 4x4 Plan to reduce obesity and improve wellness

XI.   Implement regionalization plan for health care services and programs

(Federally Qualified Health Centers, School-based Health Centers)
- Physician Organizations/Physician Hospital Organizations
- Specialists
- Hospitals/Health Systems
- Payers/Health Plans
- Behavioral health care providers (potentially including Community Mental Health Services Providers)
- Pathways Community HUBs, or other community-based entities that coordinate access to community services
- Skilled Nursing and Assisted Living Facilities
- Home Health services
- Community-based Long-term Care services and supports

Accountable Systems of Care serve a defined population within a geographic region. That population is defined as the patients enrolled or attributed to the primary care providers within the Accountable System of Care network.

Community Health Innovation Region

Cross-sector partnerships are developing across the state to address gaps in quality and access at the local level, as well as address the broad determinants that influence health in their communities. These partnerships demonstrate the ability to collaborate across partners (including competitive entities), engage leadership in the community, and garner broad-based support and funding from stakeholders. Existing partnerships struggle with sustainability as funding may be short term, and resources are contributed voluntarily.

As part of the SIM, a Community Health Innovation Region is not an organization, but a broad partnership that is supported by a backbone of key staff who are located within an existing respected and powerful entity (referred to as a 'backbone organization'). The role of the backbone organization is to convene stakeholders to implement strategies that reduce community sources of health risk. The backbone organization works with health systems and public health departments to conduct a community health needs assessment. Together, community stakeholders identify interventions and strategies to address community priorities. Additionally, within the Community Health Innovation Region, the backbone organization and its stakeholders work towards organized 'entry points' for access to community services, and accountable systems community supports and services coordination. To be effective, a Community Health Innovation Region must demonstrate inclusive partnerships and progress towards specified outcomes. The Community Health Innovation Region demonstrates value by improving health outcomes and reducing health risks in the community, thereby reducing health care costs to payers and health plans. A demonstrated return on investment enables the Community Health Innovation Region to secure sustainable funding sources that may include financial investments from local health systems, health plans, business, state and government revenues, and philanthropy.

As the Community Health Innovation Region aligns partners to work towards community health goals, it also provides a forum for engagement and alignment with other regional efforts including economic development.

Cross-sector partners in the Community Health Innovation Region should include:
- Accountable Systems of Care and their component elements (see above)
- Public Health Department
- Pathways Community HUBs
- Community Supports and Services Providers
- Businesses

- Government entities
- Community representation
- Faith-based organizations
- Nonprofit organizations
- School and Higher Education Representation
- Philanthropy

Payers

Payers/health plans contract with Patient Centered Medical Homes and Accountable Systems of Care in ways that incentivize value-based care over volume-based care. The Michigan SIM will seek alignment that reduces administrative complexity. Payers provide crucial administrative supports and alternative payment methods that allow the delivery system to function and support required patient care management infrastructure investment. They also provide crucial data functions and manage and balance financial risk through appropriate patient and population risk adjustment.

Michigan's Medicaid managed care entities are expected to benefit in the long-term from the implementation of the SIM plan. With a focus on broad investment in Patient Centered Medical Homes, supportive accountable systems of care, and organizing community engagement in community risk reduction and health improvement, the SIM initiative complements the important role the Medicaid managed care entities play in improving quality, access to care, population health, and cost containment.

Payers that the Michigan SIM will engage include:
- Michigan Department of Community Health and delegated private managed care entities
- Medicare
- Medicare Advantage Plans
- Qualified Health Plans operating on the Health Insurance Exchange
- Commercial payers
- Integrated Care Organizations
- Prepaid Inpatient Health Plans
- Foundations
- Other federal and state funding
- Community funding

Michigan Department of Community Health 2013 Strategic Priorities:

XII.	Focus on quality outcomes rather than quantity
XIII.	Streamline payment and reimbursement process for providers
XIV.	Improve fraud identification and prevention to reduce waste and increase accountability
XV.	Ensure IT systems are unified, usable, and meet future business needs
XVI.	Develop a standardized method to provide services consistently throughout the state to improve the quality of care
XVII.	Champion expanding the Health care Workforce and promote positive benefits of health care in stabilizing healthier communities

Health Information and Process Improvement Infrastructure

Michigan has invested in a number of components that will support a high quality information and improvement infrastructure. Additional investments are required to enhance connectivity, usability, and efficiency of health information exchange for care coordination, as well as aggregation of claims and clinical data to support measurement of the value of care at the provider, practice, Accountable System

of Care, and community levels. Michigan also has numerous entities that provide considerable support for health care transformation.

Infrastructure that will be enhanced includes:
- Health information exchange
- The State of Michigan Data Hub

Consideration will also be given to:
- Access to adequate data from all payers
- Investments in state and regional quality improvement and transformation resources

Finally, all aspects of Michigan's SIM require expanding Michigan's health care workforce and providing the education and training opportunities to equip health care professionals and lay personnel to practice at the top of their training and licensure in team-based settings. This will include attention to: 1) inter-professional education and practicum/residency opportunities, 2) training in self-management techniques; 3) development of definitions and curriculums for community health workers (CHWs), and 4) examination of policy changes required to enable team-based care.

Table 1: Proposed Roles of Key Elements in Michigan's SIM

Community-integrated Health System Functions	Responsibility				
	Patient Centered Medical Home (PCMH)	Accountable System of Care (ASC)	Community Health Innovation Region (CHIR)	Payers	Infrastructure
Delivers cost-effective, comprehensive, coordinated patient-/family-/community-centered care at the right place, at the right time and by the right provider (Addresses Goals 1, 2,4, and 6)					
Patient Engagement and Self-management Support	Inter-professional team members skilled in self-management support	A system of care solicits patient feedback, drives continuous quality improvement, facilitates provider-patient shared decision making, and supports patient self-management and communication using innovative technologies (e.g., mobile apps)	Supportive via community health programming and education, and engagement	Support value added care and accountability (including patient accountability) through benefit design and payment models; Invest in long-term, population-based outcomes	Patient health records (PHR); Communication tools; Provider training

Community-integrated Health System Functions	Responsibility				
	Patient Centered Medical Home (PCMH)	Accountable System of Care (ASC)	Community Health Innovation Region (CHIR)	Payers	Infrastructure
Care Coordination	Links patients to needed sources for comprehensive care; Follows protocols for communicating, sharing data, and establishing care responsibilities with other providers, reconciling medication, and timely follow-up after discharge from another setting	Organizes service and delivery system relationships and referral protocols across the ASC; Assures clinical integration of a shared patient-centered care plan and provides secure, electronic access to the care plan that is available as appropriate at each point of service; Provides and supports EHR and information exchange for ASC providers; Coordinates care with providers not part of the ASC; Communicates and coordinates with the CHIR	Supports relationships between health care and community providers	Support value added care and accountability (including patient and provider accountability) through benefit design and payment models; Invest in long-term, population-based outcomes	Health information exchange, Common data sets and references

Community-integrated Health System Functions	Responsibility				
	Patient Centered Medical Home (PCMH)	Accountable System of Care (ASC)	Community Health Innovation Region (CHIR)	Payers	Infrastructure
Enhanced Access	Implements: expanded hours; around the clock availability of clinical decision-maker; multiple patient communication methods; referrals to alternative care settings	Assures timely and necessary access to primary and specialty care including after hour care, home care; Coordinates linkages to alternative care settings	Develops/enhances systems of care that find and link underserved and vulnerable to care	Support value added care and accountability (including provider and patient accountability) through benefit design and payment models; Invest in long-term, population-based outcomes	Health information exchange; Communication tools
Prevention, wellness, development	Provides evidence-based clinical preventive and developmental services; Utilizes multi-disciplinary teams, Coordinates with community programs and public health	Disseminates evidence-based standards of care/protocols and assists providers in implementing; Coordinates primary and secondary prevention efforts with public and community health initiatives; Creates linkages between ASC providers and community resources and service providers	May organize community-based screening; Works with public health, business, schools, and local government to promote healthy environment		Clinical decision support; Electronic registries track care across populations (at practice, Accountable System of Care, and state levels); Transparent quality metrics

Community-integrated Health System Functions	Responsibility				
	Patient Centered Medical Home (PCMH)	Accountable System of Care (ASC)	Community Health Innovation Region (CHIR)	Payers	Infrastructure
Complex care management for individuals requiring intensive support services (Addresses Goals 2, 4 and 6)					
Moderate and complex clinical care coordination	Care Managers are an integrated part of the Patient Centered Medical Home health care team	Supports hiring and training of Care Managers; Develops and implements integrated care management protocols	Collaborates with clinical care managers, establishing linkages to community-based navigators/supports coordinators	Support value-added care coordination through contracting, benefit design, and payment incentives; Use population risk segmentation to facilitate early intervention and effective care management; Assist with resources before-hand to support the process	Electronic Care Management documentation; Support for care manager integration; Health information exchange
Supports and services coordination for special populations	Patient choice of Supports and Services Coordinator is honored. These Coordinators work within a sophisticated complex care coordination infrastructure , in which the team is specifically tailored to the individual's needs: behavioral health, LTC, children with complex care needs, etc.				Common patient-centered care plan; Health information exchange
Outreach to vulnerable populations, community-based Health Coaching, and care system navigation	Coordinates with HUB, community care team, home-visiting programs, and Supports Coordinators for special populations	Collaborates with and supports the development of Pathways Community Hubs, Community Care Teams, and/or other community-integrated whole person service delivery models			Software to track progress and document outcomes; Maintains Community Resource Database; Health information exchange

Community-integrated Health System Functions	Responsibility				
	Patient Centered Medical Home (PCMH)	**Accountable System of Care (ASC)**	**Community Health Innovation Region (CHIR)**	**Payers**	**Infrastructure**
Home-based services for chronic disease with social care needs, elderly, Maternal and Child Health, etc.	Coordinates care and provides referrals	Integrates the electronic patient care plan and assures coordination between home visiting services and ASC providers; Supports telemedicine capabilities and home-based electronic patient monitoring systems and technologies	Implements models to coordinate community services to maximize effectiveness and reduce duplication		
Build capacity within communities to improve population health (Addresses Goal 3)					
Key stakeholders are engaged at a community level to identify community health concerns and hold partners accountable to solutions	Participates on CHIR committees; Shares barriers to patient health & well-being and receives population level information	Participates in and contributes resources for infrastructure development of the CHIR	Serves as a neutral convener to: build coalitions, ensure community voice in population level strategies	Contribute resources	
Community health needs assessments	Supportive through participation in the CHIR, submits data and information	Participates in and supports community needs assessments	Facilitates collaboration between hospitals and public health	Support and facilitate community need assessment	Aggregate cost, quality and health data are available on a community level

Community-integrated Health System Functions	Responsibility				
	Patient Centered Medical Home (PCMH)	Accountable System of Care (ASC)	Community Health Innovation Region (CHIR)	Payers	Infrastructure
Develops goals and action plans based on community-prioritized needs	Participates	Participates in the development of community needs and priority action plans	Provides staffing to coordinate activity and monitor progress and outcomes	Support and incentivizes community health outcomes	Aggregate cost, quality and health data are available on a community level
Administrative requirements are implemented to ensure accountability for value (better care, better health at lower cost), adapt to changing evidence base, while reducing complexity and administrative costs (Goal 5, and all other Goals)					
Performance measurement and quality improvement	Ongoing monitoring of outcomes, identify areas for quality improvement, implements quality improvements at practice level	Measures ASC provider quality, cost and cost performance; Organizes and supports a systematic continuous quality improvement process; Monitors and reports health outcomes of ASC patients; Supports peer review feedback and continuing medical education and training to improve performance	Primary responsibility for quality improvement of community-based services and supports: convenes stakeholders to identify concerns and barriers, develops solutions, assesses impacts, transfers quality improvement process knowledge to community partners	Ongoing monitoring of outcomes, identify areas for quality improvement and provide feedback	Ongoing monitoring of outcomes, identify areas for quality improvement and provide feedback; All payer patient registries, Embedded care guidelines, Data aggregation tools, Patient experience surveys, Patient Advisory Committees

Community-integrated Health System Functions	Responsibility				
	Patient Centered Medical Home (PCMH)	Accountable System of Care (ASC)	Community Health Innovation Region (CHIR)	Payers	Infrastructure
HIT systems capable of exchanging electronic health information between network and out of network providers and services	Adopts and meaningfully uses electronic health record and participates in health information exchange	Works toward the ability for ASC providers to share information electronically and supports quality and performance data reporting solutions	Supports health information exchange adoption and solutions to exchange data between health and community entities, subject to privacy and security considerations	Value-based payment programs provide the business case for health information technology and health information exchange adoption and use	Interoperability solutions, Health information exchange use cases that support the SIM
Common processes: ✓ **Common metrics** ✓ **Consistent participation requirements** ✓ **Common submission processes**	Provides data and adheres to requirements; Provides input into requirements	Facilitates and supports ASC provider practices with common administrative and reporting processes, required IT implementation, practice MU and optimization, and electronic data collection, reporting, and improvement	Provides input into relevant metrics for particular communities based on community priorities	Collaborate to develop consistent definitions	Infrastructure to support efficient data gathering and submission; Body and framework for selecting and monitoring metrics and program requirements

Community-integrated Health System Functions	Responsibility				
	Patient Centered Medical Home (PCMH)	Accountable System of Care (ASC)	Community Health Innovation Region (CHIR)	Payers	Infrastructure
Requirements updated in response to new evidence and best practices	Incorporates new evidence into care processes; Provides ongoing input	Facilitates and supports practice re-engineering, training, and use of evidence-based best practices to improve Patient-Centered Medical Home performance	Assist community entities to incorporate new evidence into service delivery	Agree to metric and program updates in response to evolving evidence	Mechanisms to identify and spread best practices
Data available to decision-makers	Submits data; Reviews and utilizes information for improvement	Collects practice claims, encounter, and clinical data to monitor, report, and improve population health outcomes; Participates in public health surveillance and uses data to peer review and improve practice performance	Monitors progress toward community goals, makes information available transparently	Make appropriate levels of information available to patients, providers, ASCs, CHIRs for shared decision-making	Methodology and infrastructure to calculate metrics, conduct analyses and report results, Interpretation of information and dissemination of lessons learned

Appendix 3.5 (Cont.): August 8, 2013 SIM Advisory Committee Meeting Summary

Key Points

Payment reform was not on the agenda; however several participants noted the importance of the discussion in relation to whether the proposed model would be successful and cost-effective. Payment reform will be the topic of the next AC meeting.

On Patient and Person Engagement

- While engagement is critical, we cannot *impose* accountability on individuals. People have the right to take risks, and the system must not "abandon them to the consequences of their actions," but rather provide care and support whenever they need it.
- Some individuals may not want to participate in decision making about their care or feel that they do not have the capacity to do so. Engagement must be person- and family-centered; with both patients and families able to participate in decision making to the extent they are comfortable.
- While there is diversity in how people want to engage in their care, not many people would choose to be unhealthy, and we need to be careful not to become patronizing; that is, need to be aware of social determinants, protective factors and stressors that significantly impact health. Social determinants are inexorable from patient/person responsibility.

On the Patient Centered Medical Home (PCMH)

- There seemed to be consensus around the idea of a Michigan definition of PCMH which does not impose onerous designation requirements, but rather emphasizes the continuous pursuit of the characteristics presented. That is, a process-based definition would maximize our ability to facilitate better care without excluding the small practices which encompass many providers in Michigan.
- PCMH will still require significant support structures within a backbone community organization in order to be successful.
- Many pediatric practices are PCMHs. These, as well as programs like CHAP, may offer scalable, real-world examples of this component of the model and as such should be better emphasized.
- Behavioral health integration will be critical to ensuring that PCMHs have the impact we hope to see.
- The model assumes educated, empowered patients. To realize our goals will thus require patient/person education at all levels of the model, but especially at the provider level within the PCMH.

On Accountable Systems of Care (ASC)

- The problem of attribution among a mobile population is critical and must be addressed by the ASC.
- Risk sharing across an organization like an ASC will require a large population to be feasible.

- Insofar as Local Public Health (LPH) is both a convener and a provider of services, they ought to be included in the concept of the ASC as well as being a component of the Community Health Innovation Region (CHIR). The capabilities of LPH departments are highly variable, however, and as such may need supports in order to fulfill their roles in this system.
- Others noted that incorporating the entities listed into a true ASC would take a long time.
- We need to be realistic in the design phase about our HIT-HIE expectations; true EMR interoperability is still a long way off, so our goals should reflect the best *achievable* outcomes, not necessarily the best *conceivable* outcomes.
- AC members debated the role of health plans and provider networks in performing the responsibilities of an ASC. Health plans currently have a robust administrative network that can meet some of the responsibilities of an ASC: and are currently the entity tasked with coordinating care and maintaining costs for Medicaid beneficiaries. Whereas, providers aver care is enhanced through a comprehensive infrastructure with common care processes, quality information, and administration across all patients, regardless of payer.

On Community Health Innovation Regions (CHIR)

- The CHIR could be an entity that aggregates all-payer population information and furnishes it to providers. Convening around this issue may not be enough to effect this change.
- While the CHIR may be a necessary component of the model, it is critical that it be implemented in a way that maximizes value-added while minimizing additional burden on providers. This may require that other administrative entities give up some degree of control. The establishment of an All Payer Claims Database in Michigan would greatly improve the capacity for both the ASC and the CHIR to add value.
- The list of entities intended to participate in the CHIR is daunting. The entities listed already have roles in FQHCs and Managed Care entities, and the latter is currently being paid to perform many of the activities described. By introducing new entities we may be not only adding complexity but further diffusing responsibility, ultimately making these goals inimical to the Triple Aim. We may be better served by compelling existing entities to be accountable to others they already recognize as partners.
- The existence of an APCD could be the foundation for retrofitting ASC functions onto Managed Care Organizations. On the other hand, MCOs focus on their own populations, which does not get to commonality across payers. As an example, the CHIR in Washtenaw doesn't attempt to replace what an MCO or ACO can do, but to meet the needs of the underserved in a coherent way.
- In Jackson, collaboration efforts are struggling with relationships beyond simple cross-representation. There is an issue of redundancy of infrastructure.
- Regarding the kind of collaboration ascribed to the CHIR, it is important to ask, "Why don't counties do this now?" when most of the required resources exist in those counties already. We need to deeply understand what these barriers are before we can hope to remove them.

On Payers

- It seems as though we cannot think about funding streams to test innovations when we are required to demonstrate the value of those innovations in order to receive funding. To be able to

test the innovations in the model, hospitals and others will need to put significant capital in place, and may not ultimately realize the benefits, as payers will continue to reimburse at the margins regardless of what has been invested. This will require balancing shared savings payments versus infrastructure development models, but rather than establishing new payment strategies, we should align around what exists now rather than remaining in payer-imposed siloes.

- We need payers to compensate providers for care management activities, especially to the degree that much of this will emanate from expanded PCMH capabilities among smaller practices. In addition, payers see much more evidence on best practices at the population than individual providers do, so a transparent multi-payer database will be important to facilitate accountability at other levels of the model.

Appendix 3.5 (Cont.): August 27, 2013 Advisory Committee Meeting

The SIM Advisory Committee had its 7th meeting on August 27, 2013.

The meeting centered on the kick-off of four workgroups created to address specific details within the overall SIM Working Concept: Accountable Systems of Care and the structure thereof, Care Coordination, HIT/HIE, and Workforce. A presentation of the SIM Working Concept opened the meeting so as to bring workgroup invitees up-to-speed, after which time each group proceeded to individual break-out sessions, constituting the first of three meetings for each group. Outputs from these workgroups were incorporated into the model design.

Appendix 3.5 (Cont.): September 19, 2013 Advisory Committee Meeting Summary

Where should Michigan be headed in terms of <u>transformational</u> payment models that move us away from fee for service and towards the model specifications and goals articulated by the Advisory Committee?

Panel and audience members were not at consensus around transformational payment models. Multiple points of view that were articulated include:

<u>Community investment for population health:</u>

- Align payers to reward population level results.
- The quality of health care contributes only 20% to population level outcomes: community assets require investment.
- Align grant funding as well as payment models to support population health (for instance CMS Strong Start grants).

<u>Shared savings versus global capitation:</u>

- Implement shared savings: Savings targets are based on a specific population's characteristics.
- Do not implement shared savings: It is a zero sum game eventually, with inadequate savings to build necessary infrastructure and share with all participating entities.
- Risk adjusted global capitation provides flexibility so that organizations employing this payment mechanism can invest in redesign/quality improvement efforts that could achieve quality and cost outcomes.
- All payment mechanisms have context dependent advantages and disadvantages. For example, in a capitation payment model:
    - Cannot capitate a provider entity that does not have sufficient reserves (i.e., they can't bear the financial/performance risk due to lack of resources for infrastructure, or they have inadequate size of population for global capitation, etc.).
    - Capitation works well to control costs while improving quality in settings in which the health system can develop the needed support infrastructure and can bear financial risk

<u>Other payment principles:</u>

- Align payment for all participants in the care process (e.g., do not pay PCMH capitation and specialists FFS).
- Reward providers for taking on and sticking with the toughest patients, including those with complex psycho-social problems. This may be problematic in a capitation payment model because no risk adjustment system adjusts for all factors.
- The current FQHC prospective payment system pays PCPs for a scope of responsibilities. Centers can include nursing, dietetics, transportation, and could be expanded to include specialists.

<u>Infrastructure:</u>

- Recognize and build upon organizational infrastructure/ assets in the system, without creating additional structures to be paid.

- Aggregate, all-payer data is needed.

Recognizing different organizational capacities to implement payment reform, what do we test in the near term that will move us forward, understanding we can test more than one payment model?

Build on existing assets

- Expand MiPCT to include more payers.
- Invest in community examples with CHIR-like characteristics such as the Washtenaw Health Initiative, Allegiance Health Improvement Organization, Greater Detroit Area Health Council, or the Greater Flint Health Coalition.

Next steps for payment

- Use new codes to pay for new services (e.g., Medicare transitional care payments).
- Establish an integrated risk model with a 'shadow premium', such that money follows the person with appropriate risk adjustment.
- Partner with Health Plans to do the underwriting, so Medical Loss is not on the side of providers. Align physician incentives such that they share resources as needed to achieve outcomes (e.g., with specialists, community entities).
- Do not include certain high risk cases (e.g., high risk neonates, burn victims) when calculating expected costs for providers to manage.
- Use the savings to reinvest in community health, environmental health determinants, and the social determinants of health.
- Consider bundled payments to hub-type organizations that include community-based organizations.

Address barriers

- A 3-day hospitalization should not be required for Medicare to cover a stay in a skilled nursing inpatient facility, as this leads to unnecessary hospitalizations.

Adjust Medicare ACO model

- ACO beneficiaries should not be able to opt out of sharing information.
- Individuals should make long-term commitments to providers.
- Attribution/assignment must be prospective not retrospective.

Invest in infrastructure

- Create an all payer claims database and give Provider Organizations the data they need.
- Promote transparency.
- Track population health metrics.
- Invest in Health Information Technology and Health Information Exchange connectivity.
- Support organizational capacity (e.g., the ASCs and CHIRs).
- Support transformation at the practice level.

Additional payment principles

- Vest community organizations with responsibility
- Pay for all providers and the value they add.
- ASCs must have large volume for economies of scale and may cover multiple regions.

- Consider the interface between local structures and the ASC structure; ASCs will cross multiple regions and must interact with each community entity.

How will the payment model address patient engagement?

- Patients vote with their feet.
- Patients should prospectively select their provider.
- Require patient engagement in planning processes.
- For the ACO model, 7 of 33 metrics are related to the CAHPS score, including timely appointments and access to specialists.
- Promote self-management, as patients must be stewards of their own health.
- A key principle of a PCMH is patient involvement.
- Sharing cost data with providers is a good place to start, as PCPs will refer patients to less expensive specialists.

How will the payment model reduce administrative complexity?

- Reduce unnecessary variation in administration by instituting common practice guidelines, common definitions of a PCMH and ASC, common attribution model, aligned payment models across payers, and common formularies.
- Provide legal flexibility (for instance if I as an ASC want to pay my patients to have their A1C test).
- Simplify the community referral process (the Pathways Hub is one model).

Appendix 3.6: Focus Group One: Systems of Care
Organizational Representation
Priority Health
Area Agencies on Aging Association of Michigan
Michigan Association of Health Plans
Michigan Osteopathic Association
Auto and Home Insurance Program of Michigan
University of Michigan
Greater Detroit Area Health Council
Detroit Medical Center
Faculty Group Practice at University of Michigan
Michigan Health and Hospital Association
Blue Cross Blue Shield of Michigan
West Michigan Community Mental Health System
Blue Cross Blue Shield of Michigan
Intern at University of Michigan; Center for Value-Based Insurance Design
School Community Health Alliance of Michigan
Munson Health System
West Michigan Community Mental Health
Genesys Physicians Health Organization
University of Michigan: Center for Value-Based Insurance Design
Michigan Health and Hospital Association
Michigan Center for Clinical Systems Improvement

Appendix 3.7: Focus Group Two: Linkages and Cross-Sector Partnerships

Organizational Representation
Michigan State Medical Society
Priority Health
Greater Detroit Area Health Council
Allegiance Health
Health Department North West Michigan and Michigan Association of Local Public Health
Michigan Department of Community Health, Bureau of Family, Maternal & Child Health; Public Health Administration
Michigan Department of Community Health, Division of Family & Community Health; Public Health Administration
Michigan Department of Community Health, Bureau of Community Mental Health Services; Behavioral Health & Developmental Disability Administration
Michigan Department of Community Health, Employee Health Management
Michigan Department of Community Health, Affiliate
School Community Health Alliance of Michigan
Ingham County Health Department
University of Michigan, Center for Healthcare Research and Transformation
Blue Cross Blue Shield of Michigan
University of Michigan
Blue Cross Blue Shield of Michigan
Michigan Department of Community Health
Washtenaw Health Initiative, Center for Healthcare Research and Transformation
Greater Detroit Area Health Council
Community Mental Health of Clinton-Eaton-Ingham Counties
Blue Cross Blue Shield of Michigan
Department of North West Michigan
Matrix Human Services - Detroit
Blue Cross Blue Shield of Michigan
Michigan Council for Maternal and Child Health

Appendix 3.8: Focus Group Three: Primary Care Transformation

Organizational Representation
Michigan State Medical Society
Michigan Association of Health Plans
Auto and Home Insurance Program of Michigan
University of Michigan
Mott's Children's Health Center
Michigan Primary Care Association
Blue Cross Blue Shield of Michigan
West Michigan Community Mental Health System
Michigan State University College of Nursing Life Science
Michigan Chapter American Academy of Pediatrics
Michigan Department of Community Health, Division of Family & Community Health; Public Health Administration
Michigan Department of Community Health, Bureau of Community Mental Health Services; Behavioral Health & Developmental Disability Administration
Michigan Department of Community Health, Office of Health Information Technology
Michigan Department of Community Health, Affiliate
Blue Cross Blue Shield of Michigan
School Community Health Alliance of Michigan
Oakland Court CMH Authority
Intern at University of Michigan; Center for Value-Based Insurance Design
Medical Advantage Group
Centra Wellness
Centra Wellness
University of Michigan
Washtenaw Community Health Organization
Practice Transformation Institute
Practice Transformation Institute

Appendix 3.9: HIT-HIE Work Group

Organizational Representation
Michigan Department of Community Health
Michigan Department of Technology, Management and Budget
University of Michigan Health System
Michigan Department of Community Health
Medical Advantage Group
University of Michigan School of Public Health
Michigan Department of Technology, Management and Budget
University of Michigan Clinical Systems Management, Michigan Data Collaborative
Michigan State Medical Society
Jackson Health Network
Michigan Department of Community Health
Michigan Health Information Network Shared Services
Oakland Court Community Mental Health Authority
Michigan Health Information Network Shared Services
Altarum
Michigan Department of Education-Office of Great Start
Intern at University of Michigan; Center for Value-Based Insurance Design
Upper Peninsula Health Care Network
Timely, Beneficial, Dynamic Solutions
Michigan Center for Effective Information Technology Adoption
Southeast Michigan Beacon Community
Mackinac Straits Health System
Michigan Health & Hospital Association
Blue Cross Blue Shield of Michigan
Michigan Consumers for Healthcare
Michigan Department of Community Health
Michigan Public Health Institute
Michigan Department of Technology, Management and Budget
Michigan Department of Community Health

Appendix 3.10: Health Information Technology-Health Information Exchange Work Group Charter

Purpose:

The purpose of the HIT-HIE Work Group is to determine how technology supports, enables and provides the foundation for the State Health care Innovation Plan (SHIP), keeping in mind the SIM goals to determine what data and what infrastructure are needed in order to:

- strengthen primary care infrastructure
- support coordinated care for individuals with intensive support needs
- improve systems of care to ensure appropriate utilization of health care services
- build capacity within communities to improve population health
- reduce administrative complexity

Critical to the success of the above goals and ultimately of a transformed health care system is interoperable health information exchange (HIE) among a variety of health care stakeholders. A strong HIT and HIE infrastructure is foundational in improving population health, care coordination, and patient empowerment; all key factors in hardwiring the triple aim.

Individuals and communities need ready access to necessary information in order to make the best possible health-related decisions. Just as information must "follow the patient" and be used meaningfully to support the provision of appropriate, person-centered care, so must aggregated information about individuals and the environments in which they live be available to inform decisions that will impact health.

A critical factor in enabling HIE is consensus among a variety of stakeholders. Often, complex technical and policy choices are required and, ultimately a governance structure is established to provide oversight and accountability to parties involved in the exchange of electronic health information.

Some questions to consider:
- What governance needs to be in place, at what levels?
- Who owns the data? Where does it rest? Who can manage it?
- Consistent security and privacy policies for sharing data?
- What data elements are stored? Shared?
- Statewide standards for electronic data?
- Who can see what data? Who can amend?
- Who processes accountability?
- What are appropriate accountability measures for HIT vendors and HIE providers?

Expected Outcomes:

The group will create a report for the SIM team detailing:
- What are the underlying technical and governance infrastructure needs to support the SHIP and the to-be community integrated health system?
    - Technology standards

- o Policy
- What are the barriers related to electronic communication and the seamless flow of information?
  - o Technology
  - o Policy
  - o Roadmap to remediate barriers
- Recommendation to SIM
  - o 5-year implementation plan

Time Expectations/Meetings:
- The HIT-HIE Workgroup will be convened for a total of three meetings expected to occur between August - September 2013.
- The Workgroup will meet either in person in the Lansing area or via phone or web conference.

Reports to Management Team:
- Workgroup recommendations will be submitted to the Management Team for incorporation into the SHIP.
- Facilitation of the Workgroup will be designed to achieve a high level of consensus on recommendations for the SHIP. It is unlikely, however, that all recommendations will be unanimous. Minority views/perspectives will also be shared with the management team.

Appendix 3.11: Workforce Work Group
Organizational Representation
McKenzie Hospital
City Connect - Detroit
Central Michigan
War Memorial Hospital
University of Michigan, Institute for Healthcare Policy and Innovation
Grand Valley State University/College of Nursing
Michigan Health Council
Public Health Institute
Southeast Michigan Areas Health Education Center
Michigan Center for Rural Health
Michigan State Medical Society
University of Michigan, Health System
Greater Detroit Area Health Council
University of Michigan School of Public Health
Michigan State University College of Nursing Life Science
Area Agencies on Aging Association of Michigan
Michigan Department of Education
Michigan Chapter American Academy of Pediatrics
Michigan Association of Community Mental Health Boards
Michigan State University College of Nursing Life Science
Michigan Department of Community Health, Medical Services Administration
Michigan Department of Community Health, Office of Nursing Policy
Michigan Department of Community Health, Public Health Administration
Michigan Department of Community Health, Chief Medical Executive
Michigan Department of Community Health, Division of Family & Community Health; Public Health Administration
Michigan Department of Community Health, Policy & Planning
Michigan Department of Community Health, Affiliate
Michigan Department of Community Health, Behavioral Health & Developmental Disability Administration

Appendix 3.12: Workforce Work Group Charter

Purpose:

Identify strategies to enhance and build capacity for the delivery of primary care. Topics to consider:

- How to foster broader implementation of inter-professional practice (IPP) teams in primary care offices
- How the use of health information technology (HIT) can support primary care practices in decision making

Questions:

Inter-professional practice:

The model calls for inter-professional team members skilled in self-management support and the use of multi-disciplinary teams to support the delivery of cost-effective, comprehensive, coordinated patient-/family-/community-centered care at the right place, at the right time, and by the right provider. Inter-professional practice empowers each team member to work as an essential partner of a health care team while practicing at the height of their training, thus expanding workforce capacity.

1) What needs to be in place to support inter-professional practice in primary care settings?
   o What might prevent a practice from delivering care using an inter-professional team?
   o How can a health system or physician organization ensure that its practices have the human and other resources they need to deliver care using an inter-professional team?
   o How can smaller and/or rural practice settings be supported in using an inter-professional team?
   o How can the role of non-physician health professionals on the care team be supported?

Health information technology:

The model calls for PCMHs to adopt EHRs and join HIEs, review and use data to identify places for improvement, and incorporate new evidence into care processes, and adhere to common metrics.

2) How can health information technology be used in primary care practices to support prudent decision making, including appropriate use of specialists and risk assessments?

Appendix 3.13: Care Coordination Work Group

Organizational Representation

Michigan Primary Care Transformation Project
Michigan Health and Hospital Association
Michigan Department of Community Health
Michigan Department of Community Health
University of Michigan
NexCare Health Systems
Mid-Michigan District Health Dept.
Flinn Foundation
Michigan Department of Community Health
Physicians Health Plan
Meridian Health Plan
The Senior Alliance, Area Agency on Aging 1-C
First Steps
Greater Detroit Area Health Council
Cherry Street Health Services
Michigan Peer Review Organization
Veda A. Sharp and Associates, Limited Liability Company
The Senior Alliance, Area Agency on Aging 1-C
Michigan Health and Hospital Association
Midwest Health Plan
Michigan Health Information Network Shared Services
Pine Medical Group
Michigan Council for Maternal and Child Health
Area Agencies on Aging Association of Michigan
Faculty Group Practice at University of Michigan
West Michigan Community Mental Health
Michigan Association of Local Public Health
Michigan Department of Community Health, Division of Family & Community Health; Public Health Administration
Michigan Department of Community Health, Bureau of State Hospital & Behavioral Health Admin. Operations; Behavioral Health & Development Disability Admin.
Michigan Department of Community Health, Program and Partnership Development Division; Michigan Office of Services to the Aging
Michigan Department of Community Health, Program Policy Division; Medical Services Administration
Michigan Department of Community Health, Affiliate
Michigan Department of Community Health, Behavioral Health & Developmental Disability Administration

Appendix 3.14: Care Coordination Work Group Charter

Overview:

People with complex medical and social needs often receive services from a variety of providers in a variety of settings. Due to the complexity of the health system, it can be very challenging for patients to navigate the system and for systems to ensure that individuals receive the right services at the right time from the right provider. Many providers and settings (including medical practices, hospitals, behavioral health agencies, managed care plans, and others) offer some form of care coordination service or case management, but these are rarely well connected. The result is confusion, wasteful spending, and inability to evaluate if there has been any value-added.

Some components of care coordination or disease management programs in health care settings that have achieved desired outcomes, including positive return on investment are:

- Services are targeted toward individuals at high risk for medical complications.
- Care coordinators are provided with timely information on hospital and emergency room admissions and discharges so they can provide supports during transitions of care.
- Care coordinators provide substantial amounts of in-person and telephone contact with clients.
- Care coordination services are integrated into team-based care and there is frequent contact between the care coordinator and the primary care physician.

Care coordination models used in primary care settings commonly embed a nurse, social worker or a multidisciplinary team within the primary care practice. Other models deploy community-based teams made up of a variety of professionals (e.g., nurse care coordinators, nurse practitioners, social and mental health workers) and/or peer support workers (e.g., community health workers, outreach workers). Whichever model is used, proper care coordination should allow for seamless transitions across the health care continuum in an effort to improve outcomes and reduce errors and redundancies.

Complex Care Management in the SIM Draft Model

To support complex care management for individuals requiring intensive support services, the SIM Draft Model calls for the inclusion of Care Managers in the PCMH health care team. Special populations (e.g., behavioral health, long-term care, children with complex care needs) could also have a Supports and Services Coordinator of their choosing. The ASC would be responsible for supporting the hiring and training of Care Managers, and developing and implementing care management protocols. PCMH Care Managers would be responsible for coordinating services with Pathways Community HUBs, community care teams, home visiting programs, and Supports Coordinators.

Workgroup Objectives and Discussion Questions

Workgroup Objectives

1. Provide recommendations for ensuring that care and services for people with complex medical and social needs are coordinated across the community-integrated system, including:

   a. Care provided by multiple health care specialists;

    b.   Coordination of follow up appointments and provision of supportive services, including medication reconciliation, transitions of care from a hospital or rehabilitation center to home, or from home to a long-term care setting.

    c.   Connecting individuals to needed supports and services within the community.

Workgroup Discussion Questions

1. What appeals to you or resonates with you in the provided definitions of terms related to care coordination? What key concepts are important to incorporate as we work to integrate the coordination of services and supports for people with complex medical and social needs in the Michigan SIM?

2. Drawing from your own knowledge and experience with care coordination, what processes and/or infrastructure support cross-program or cross-system coordination of care for people with complex medical and/or social needs? What barriers exist to effective cross-system or cross-program coordination for this population?

3. How can care coordination be carried out to ensure that people are connected to appropriate medical, behavioral health, and community-based services while limiting duplication of coordination efforts?

    a.   What processes and infrastructure need to be in place to streamline care coordination across the system?

    b.   What relationships should be established among settings and coordinators?

    c.   How can technology and information sharing processes be used to facilitate communication between care coordinators, health care providers, and community services providers?

4. How should the value-added aspects of care coordination be measured relative to better health care, improved health outcomes, and reduced costs?

5. How can the collection and analysis of data be used for performance evaluation and accountability, and to support continuous quality improvement?

Appendix 3.15: Accountable Systems of Care Work Group Members

Organizational Representation
Genesys Physician Health Organization
Oakland County Community Mental Health
Trinity Health
Michigan Primary Care Association
Michigan Department of Community Health - Legal Affairs
Blue Cross Blue Shield of Michigan
University of Michigan - Internal Medicine and Medical Education
Michigan Chamber of Commerce
Michigan Association of Health Plans
Small Business Association of Michigan
Priority Health
Detroit Medical Center
Michigan State University - Institute for Health Policy
Michigan Manufacturers Association
Mott Children's Health Center
Allegiance Health
Michigan Primary Care Association
Michigan Department of Human Services - Policy & Field Legal Services
Michigan Chamber of Commerce
Michigan Association of Local Public Health
Michigan Department of Community Health - Health Care Reform; Medical Services Administration
Michigan Department of Community Health - Chronic Disease/Injury Control Division; Public Health Administration
Michigan Department of Community Health - Medical Services Administration
Michigan Department of Community Health - Bureau of State Hospitals & Behavioral Health Admin. Operations; Behavioral Health & Developmental Disability Admin.
Michigan Department of Community Health - External Relations & Communication
Michigan Department of Community Health - Bureau of Medicaid Policy & Health Systems Innovation; Medical Services Administration
Health Management Associates
Governor's Office – Health Exchange
Health Management Associates

Appendix 3.16: Accountable Systems of Care Work Group Charter

Purpose:

In the Michigan SIM, the Accountable System of Care (ASC) is proposed to be an integrated network of providers and clinical and non-clinical services that facilitates and supports the infrastructure for network providers to proactively coordinate comprehensive care management for a defined population. ASCs are accountable for improving the quality of care and care experience for patients served by network providers while lowering costs for the patient population served by those same providers. ASCs are the vehicle to integrate population health improvement strategies with broader community health initiatives (for example, childhood obesity reduction, breast cancer screening, or healthy senior initiatives).

The Patient Centered Medical Home (PCMH) is the foundation of the Accountable System of Care health care delivery system. To reduce administrative complexity, the Michigan SIM will develop strategies for multi-payer alignment with common outcome measurements, performance standards, reporting processes, and administrative requirements, including common approaches to beneficiary assignment, organization governance, risk-based alternative payment methods, and certification and/or accreditation for ASCs.

Expected Outcomes

The group will create a report for the SIM team detailing:

- Accountable System of Care roles and responsibilities for supporting and improving care coordination and Patient Centered Medical Home functions
- Technical issues around Accountable System of Care requirements
- Payment model considerations

Discussion Questions

Accountable System of Care Roles and Responsibilities

Review Table 1 in the SIM Straw Model Design

- Do we agree with the Accountable System of Care responsibilities in the SIM?
- Are there additional important responsibilities?

Technical Considerations and Planning

Care is provided to a distinct ASC population, large enough to be able to show a clear impact on organized care delivery. The ASC must include a methodology for defining the ASC patient population.

ASC Designation

- Who or what can be an ASC?
- What are the core requirements of ASC governance structure?
- What are the supportive network infrastructure elements and capabilities that an ASC should have?
- What are the minimum requirements for connective health information technology?
- Is ASC designation based on the population empaneled to the network's primary care providers or is it based on a service area?

- Should ACS designation criteria be developed to recognize incremental steps towards network development?
- What is the role of ASC in workforce development, training, primary care capacity development and appropriate geographic distribution of caregivers?

ASC Population
- How should we define the population (designation, enrollment, or attribution)?
- What policies and methodologies should be considered for ensuring inclusion of vulnerable populations (e.g., Medicaid, or at-risk populations)?

PCMH Designation
- What are minimum requirements for recognition as a primary care medical home within the ASC?
- What are areas of potential multi-payer agreement and flexibility on PCMHs?

Payment Models for Accountable Systems of Care

A new financial model must be established that aligns provider incentives to meet cost, quality and health status improvement objectives rather than basing payment on service volume.

- What are the elements of the ASC payment model?
- What is the process for establishing and reporting common cost, quality, and health status metrics for value-based payment or pay-for-performance incentives?

Proposed Membership

- Payers
- Accountable Care Organization and Organized System of Care Leaders
- Providers
- Patients/Consumers and Advocates

Time Expectations and Meetings

The Accountable System of Care Work Group will be convened for 2-3 meetings: the kickoff meeting, plus one or two additional meetings to be held by September 16. Specific dates for these meetings will be announced based on the availability of work group members.

The work group will meet either in person in the Lansing area and/or via web conference.

Appendix 3.17: Design Deliberations by Notice of Award Topic Area

This appendix describes the discussions that took place, or areas that have been identified for future follow-up, during the creation of Michigan's Health Innovation Plan.

Topic A	*Review and identify options for creating multi-payer (including Medicare, Medicaid, Children's Health Insurance Program, and state employee health benefit programs) strategies to move away from payment based on volume and toward payment based on outcomes;*
Deliberation	During development of the State Innovation Model, it became clear that any strategies chosen to help Michigan successfully move away from fee-for-service and other volume-based payment models to outcome based payment models would be challenging. In addition, any changes would be contingent on multiple, interdependent variables that will need to be identified and addressed. Different types of payment models were discussed as described in chapter C. Developing strategies for multi-payer payment reform took many different forms.
	The Accountable Systems of Care Work Group suggested strategies for multi-payer alignment with common outcome measurements, performance standards, reporting processes, and administrative requirements. Recommendations included common approaches to beneficiary assignment, organization governance, risk-based alternative payment methods, and certification and/or accreditation for Accountable Systems of Care. Without these alignments, multi-payer payment reforms would be likely to increase administrative complexity.
	The work group recommended that the state take on the role of ensuring alignment of metrics across multiple payers. It was generally agreed that there would be one or more competing Accountable Systems of Care in most regions of the state, and Patient Centered Medical Home practices would have the ability to choose to pursue a relationship with the strongest Accountable System of Care in their region. Transparency is a key principle and a driver for the Accountable System of Care selection process, as all Accountable System of Care entities will be measured by the same standards.
	There was agreement that Patient Centered Medical Homes would be foundational to the engagement of providers and patients in changing the way care is delivered, measuring performance, and accepting new approaches to payments for services. Work group members generally agreed that there must be a common baseline definition, with providers evaluated against a common core set of expectations. In addition, the multi-payer property of an Accountable System of Care is critical in harmonizing these definitions, as well as in generating agreement on patient attribution rules and avoiding duplicative activities on the part of payers.
	Recognizing that not all payers are fully engaged in pursuing alternative methods of care delivery and payment, the work group emphasized the need for flexible

performance standards based on common metrics as a strategy to reduce provider burden and encourage payer collaboration. The Michigan Medicaid agency has a key role in pushing for change through policy and programmatic levers.

In order to achieve meaningful inclusion of safety net providers, work group members recommended that the State Innovation Model include specifications for a well-defined population, a defined network of providers, and a means for "risk adjustment" that would take into account social and environmental barriers. This would go beyond the standard risk adjustment methodologies used to predict disease burden and/or future service utilization and cost.

The work group agreed that transformation of the health care delivery system would require data to drive improvement, including the creation of an all-payer claims database. There was discussion about possible expansion of the Michigan Data Collaborative to provide the infrastructure for this component of the State Innovation Model design. There was also mention of the state taking on this role through expansion of the state's data warehouse.

Some stakeholders felt the existing structure of highly functional, risk-bearing Medicaid Health Plans could assume many of the roles and responsibilities of the Accountable System of Care as described in the State Innovation Model Working Concept paper. It was noted that managed care organizations currently provide most of the Accountable System of Care's functions related to care coordination. Stakeholders representing primary care physicians and health systems felt that Accountable Systems of Care could be formed around existing organizations, such as the current physician organizations and physician hospital organizations. Providers also noted that they currently have to comply with multiple managed care requirements such as differing care coordination protocols. Complying with these different standards adds to administrative cost and burden. The Accountable System of Care role includes organizing requirements among multiple health plans in order to reduce administrative complexity and streamline processes for Accountable System of Care providers.

See chapter E for a full description of the proposed payment models.

Topic B	*Work to develop innovative approaches to improve the effectiveness, efficiency and appropriate mix of the health care work force through policies regarding training, professional licensure, and expanding scope of practice statutes, including strategies to enhance primary care capacity, and to better integrate community health care manpower needs with graduate medical education, training of allied health professionals, and training of direct service workers; and move toward a less expensive workforce that makes greater use of community health workers when practicable;*
Deliberation	The Workforce Work Group was convened to identify strategies to enhance and build capacity for the delivery of primary care. This work group was composed of a variety of stakeholders, including: consumers, physicians, community supports and services,

hospitals and health systems, payers, government, business, safety net, and universities (See appendix 3.11 for the full membership). This group met three times over a one-month time span. They were asked specifically to consider how to foster broader implementation of interprofessional practice teams in primary care practices, and how the use of health information technology could support decision-making in primary care practices. Additional input on workforce development was gathered through the advisory committee, management team, focus groups, and public outreach meetings.

The work group identified barriers that might prevent a practice from delivering care using an interprofessional team and discussed what would need to be in place in order to support interprofessional teams in primary care settings. This discussion included how a health system or physician organization could support affiliated practices to assist the delivery of care using an interprofessional team and how non-affiliated practices could be supported in the use of these teams. Barriers to developing interprofessional teams in primary care include: a lack of resources (both staffing and financial); lack of training on working in a team environment; inconsistent definitions of what an interprofessional team looks like and how a team is operationalized; a perception that there is not enough time to train staff in the office to work on a team; not having enough physical space in a facility or office for delivery of services by multiple team members; and the physician's legal responsibility to his/her patient along with the perceived risk associated with that responsibility. Work group members suggested that all of the pieces to implement an interprofessional team (money, training, space, etc.) need to be addressed as a whole, otherwise interprofessional team care would be at risk.

Work group members agreed that health systems and/or physician organizations could act as an important resource to primary care practices by providing information on the fundamentals of interprofessional team care including: guidance on how to develop and implement an interprofessional team, technical support, training, mentorship, and conveyance of the value and benefits of interprofessional teams. Technology was also viewed to have a positive impact, if used by health systems or physician organizations to support interprofessional practices.

The members found that the makeup of an interprofessional team should be driven by patients and their needs. It was acknowledged that this may be more difficult in rural areas where the availability of providers is limited, and strategies would need to be developed to overcome this issue. Work group members discussed the value of utilizing community health workers on health care teams in order to properly engage vulnerable patient populations and link to existing community-specific assets.

The following key themes arose in the work group's discussion of strategies for supporting interprofessional practice:

> Health care teams must be person-centered. The composition and operation of a health care team depends on the needs of the patient.

Team composition is critical to successful outcomes. The health care team must include the health care professionals and other service providers that can best meet the needs of the patient. The team that is right for a particular patient may be structured to include members who are not typically thought of as "professionals" or "disciplines." Therefore, the work group suggested using the term "health care team" for a team that may include providers of primary and specialty medical and nursing services; pharmacists; behavioral health providers; community health workers; patient navigators; long-term care and home health providers; social support service providers; and other service providers. It will be important to permit flexibility at the practice level for creation of teams that are most effective for the patient.

Culture shift is needed from both health care providers and payers in order for the wide-spread adoption of health care teams. The focus must be on utilizing all available resources to meet the patient's needs. This requires understanding the value and fundamentals of team work, including respectful communication, dialogue, and building intentional relationships.

Building on best practices to leverage the work already accomplished in Michigan to develop and implement health care teams. There is a need to identify and disseminate best practices and the lessons learned from various approaches.

Maximizing contributions of team members to allow teams to function efficiently. This requires all members practicing at the top of their license and skill level. Michigan's Health Innovation Plan should include identifying and eliminating potential barriers as part of the test of the model.

Redesigning reimbursement for health services should to increase efficiency by paying for the delivery of services by team members practicing at the top of their license and skill level. Reimbursement should also support health care teams by paying for the costs associated with building, training, and sustaining an effective team.

Innovative technology that is both flexible and creative in order to meet the needs for communication and sharing of information among patients, families, and all health team members. Solutions need to be found to alleviate connectivity issues, especially for providers in rural areas, and to increase patients' access to care based on their individual circumstances.

Work group participants recognized the importance of the broader issue of whether the health care workforce—in terms of numbers, types of practitioners, and capacity—could meet the demand for care in Michigan communities, or how to solve the pressing issues of supply and distribution of health care practitioners. They noted current efforts to create a database of providers that could eventually be used within regions to assess supply and develop plans to address gaps. Participants agreed that a better understanding of supply and demand for health care will be critical to meet the needs for health care in Michigan. This information will help communities identify the number and type of practitioners available to build health teams for delivery of care,

	and it will help academic institutions and technical assistance resources know what type of practitioners to prepare and to whom they should be providing technical assistance.

The work group recommended that the State Innovation Model include pilots of different models for delivery of care by health care teams. They also offered several specific suggestions for consideration in the design, implementation, and technical assistance and support of health care team pilots.

See chapter G for more detail on workforce development strategies and the role of health care teams in Michigan's Health Innovation Plan. |
| *Topic C* | *Review and identify options for aligning state regulatory authorities, such as certificate of need programs (if applicable), to reinforce accountable care and delivery system transformation or develop alternative approaches to certificate of need programs, such as community-based approaches that could include voluntary participation by all providers and payers;* |
| **Deliberation** | Reinventing the health care system is one of the top ten strategic priorities articulated by the current state administration, led by Governor Rick Snyder. In response to the Governor's priorities, the Michigan Department of Community Health will work to continue to align State Innovation Model goals across the department, identify administrative barriers to integration, as well as identify leverage points and propose solutions to address them.

Michigan's Certificate of Need Commission:
The Commission works in conjunction with the Michigan Department of Community Health to review standards every three years, as technology advancements and quality issues evolve. With the assistance of The Michigan Department of Community Health, future discussion can occur around how Michigan's Health Innovation Plan goals could be aligned with the Certificate of Need Commission's goals to ensure that community needs are being met. The State Innovation Model structure could be a valuable tool to assist the Commission in promoting the availability and accessibility of quality health care services at a reasonable cost.

Practitioner Licensing and Scope of Practice:
The primary statute governing Michigan's health professionals is the Michigan Public Health Code—Public Act 368 of 1978—as amended. Currently, there is proposed legislation that may "consolidate and update the licensure and regulatory regimes imposed on physicians, osteopaths, physician assistants, and advanced practice registered nurses." This legislation has the possibility of impacting workforce development, and if the bill passes both houses, a careful analysis and further discussion by the Department of Community Health and State Innovation Model stakeholders will be warranted.

Michigan Diversion Council and Michigan Mental Health Commission: |

The Michigan Diversion Council and the Michigan Mental Health Commission are working to help integrate behavioral health information with physical health information. Management team members sit on several of the Mental Health Commission work groups and are a part of this ongoing discussion around mental health issues in Michigan. The final report of the Michigan Mental Health Commission will be issued on December 20th, 2013.

Michigan Department of Community Health Office of Legal Affairs:
Several legal issues arise when discussing information sharing among competing companies, requiring continued work with the Department of Community Health's Department of Legal Affairs. Members of the planning team met with the Department of Legal Affairs to discuss potential antitrust issues that might arise due to the formation of Accountable Systems of Care, and strategies for avoiding them (See topic M). In addition, members of the planning team and the Department of Legal Affairs attended the Center for Medicare and Medicaid Innovation Webinar: Antitrust Issues for Various Potential Payment and Delivery System Initiatives. It will be important to engage the Attorney General's Office to seek additional guidance on structuring legal agreements to avoid antitrust, Stark and Anti-kickback laws that might arise due to the formation of Accountable Systems of Care and to develop a strategy for avoiding unintended anticompetitive outcomes.

Proposed/Pending Legislation:
Establish and administer a "health care transparency" database within the department of community health detailing claims for the payment of health care services throughout the state. This type of database is often referred to as an "All-Payer Claims Database," and will align with national, regional, and other uniform All-Payer Claims Database standards.

Additionally, State Innovation Model project staff will need to continue to involve and inform the Department of Insurance and Financial Services to discuss possible regulatory and policy levers that might support multi-payer collaboration and participation.

As mentioned previously, Michigan's Health Innovation Plan calls for the Department of Community Health to coordinate the many state policy levers that will drive participation in the Health Innovation Plan as well as the infrastructure investments to support it, and provide overall accountability for implementation and evaluation. Alignment across state government aids effective and efficient program quality improvement and all of these initiatives will continue to be watched.

Topic D	*Review and identify options for restructuring Medicaid supplemental payment programs to align the incentives with the goals of the state's payment and delivery system reform Model;*
Deliberation	The State Innovation Model advisory committee and the Accountable Systems of Care Work Group did not specifically discuss Medicaid supplemental funding mechanisms,

although Medicaid supplemental payments were discussed in general with representatives of the Michigan Department of Community Health.

The Department of Health and Human Services, through the Centers for Medicare and Medicaid Services, is the single largest funder of graduate medical education. This is the training that medical school graduates receive as residents in more than 1,000 of the nation's teaching hospitals. In Michigan, the capitation rates paid by the Michigan Department of Community Health to the Medicaid Health Plans are developed by applying a trend factor and adjustments for policy and program changes, and include Graduate Medical Education payments. Given the significant role of the Medicaid managed care system in Michigan, Graduate Medical Education payments are a potential component of supplemental funding that could be restructured to align with the goals of the State Innovation Model.

Through the Health Innovation Plan, Medicaid will consider model testing strategies that target Graduate Medical Education monies to the expansion of primary care in Michigan. The number of specialist physicians still outweighs the number of primary care doctors by about two to one. This contrasts with the situation in many other countries, where numbers of primary care physicians and specialists are roughly equal. The relatively weak role of primary care in United States health care may help explain why other countries achieve better and more cost-effective health outcomes than the United States.[1] One strategy may include the use of model testing funds to create new residency slots in rural hospitals that are linked via telemedicine to teaching hospitals that belong to an Accountable System of Care.

Topic E	*Review and identify options for creating opportunities to align regulations and requirements for health insurers with the broader goals of multi-payer delivery system and payment reform;*
Deliberation	Members of the planning and management teams met with the Department of Insurance and Financial Services to discuss possible regulatory and policy levers that might support multi-payer participation. The Healthy Michigan Plan (Medicaid expansion in Michigan) and the health insurance marketplace require insurers to work with the Department of Community Health on a number of contract changes, including identifying performance metrics and performance bonus incentives. In addition, the Department of Insurance and Financial Services and the Department of Community Health will work together on assessing the feasibility and functionality of an all-payer claims database, which will help align requirements for reporting and measuring performance for the transition to a pay-for-value system.

Topic F	*Review and identify options for creating mechanisms to develop community awareness of and engagement in state efforts to achieve better health, better care, and lower cost through improvement for all segments of the population, by:*
	    1) developing effective reporting mechanisms for these outcomes;
	    2) developing community-based initiatives to improve these outcomes;
	    3) developing potential approaches to ensure accountability for community based

	outcomes by key stakeholders, including providers, governmental agencies, health plans, and others;
	4) *coordinating efforts to align with the state's Healthy People 2020 plan, the National Prevention Strategy, the National Quality Strategy, the Million Hearts Campaign and the state's health information technology plan; and*
	5) *coordinating state efforts with non-profit hospitals' community benefits/community building plans;*
	6) *achieving greater coordination between health care providers and public health authorities;*
Deliberation	Michigan's Health Innovation Plan offers full details on the points addressed in topic F. Engaging communities across the state was the charge of the management team and directed by the planning team. Because of the comprehensive nature of Michigan's State Innovation Model design process, key community stakeholders were asked to disseminate information about the initiative to their constituencies, and a public website was created to inform all interested parties. The site remains available to collect feedback on the Health Innovation Plan, once complete, and implementation efforts. Please see the discussion in chapter C.
	Lead stakeholders of initiatives such the National Quality Strategy and other state-based initiatives were invited to participate in the State Innovation Model design process. There was significant overlap in the stakeholder groups, and information about each initiative was shared when the occasion arose. For example, Michigan participated in the Trailblazers initiative. The same staff that examined the National Quality Standards for alignment with other quality reporting requirements in Medicaid program participated in the State Innovation Model design process and shared documentation and lessons learned. Because Michigan is a state with a strong Health Information Technology-Health Information Exchange community (see topic N), the Medicaid Health Information Technology Plan is foundational to Michigan's Health Innovation Plan infrastructure development.
Topic G	*Review and identify options for coordinating State-based Health Insurance Marketplace activities with broader health system transformation efforts;*
Deliberation	Although a plan was developed, Michigan ultimately did not develop a state-based marketplace. The Department of Insurance and Financial Services worked with the Center for Consumer Information and Insurance Oversight to retain some control, and the state is providing plan management for the federally-facilitated exchange. The Department of Insurance and Financial Services is working with the State Innovation Model teams to examine the powers of the department to encourage innovation and alignment among payers. The Governor's Office is working with the Michigan Department of Community Health to provide guidance and input through the management team.
	There was keen interest in the Navigator grants statewide, and the recipient of the largest award, Michigan Consumers for Healthcare, is on the State Innovation Model advisory committee. They are working with the State Innovation Model teams and with the Michigan Medicaid Health Information Technology Consumer Engagement effort

	to align and leverage messaging opportunities.
Topic H	*Review and identify options for integrating the financing and delivery of public health services and community prevention strategies with health system redesign models;*
Deliberation	Stakeholders continuously elevated the issue of integrating the financing and delivery of public health services and community prevention strategies within the Michigan State Innovation Model. The emphasis within the model on innovation toward improving population health is well aligned with the vision of a healthier Michigan articulated by Governor Snyder and the Department of Community Health. This carried through to the management team, which sought to underscore the importance of a more responsive public health infrastructure that included cross-sector partnerships for population-level strategies, and encouraged community development and investment for improving health. The advisory committee, which included representation from public health departments at both the state and local level, was highly interested in enhancing the capacities of the public health system to better support health care providers in improving patient outcomes. Other advisory committee members represented innovative health coalitions working to build connections across sectors. Physicians participating on the advisory committee, with experience in Patient Centered Medical Home programs moving toward pay-for-value models, noted that a high-functioning public support system, including public health and other social services, was critically necessary to their ability to achieve quality and cost targets. The advisory committee ultimately recommended the development of Community Health Innovation Regions, which embody the principles of community engagement and community integration in health systems. The community, they agreed, is central to the system as a whole, and cross-sector partnerships with public health, the delivery system, community resources, and social service agencies should be fostered and included in potential risk-sharing arrangements based on the overall health of the population. Complementing the input from the focus groups, targeted interviews and outreach meetings were conducted with additional stakeholders from across the state, including the Washtenaw Health Initiative, the Greater Flint Health Coalition, Jackson's Health Improvement Organization, and the Greater Detroit Area Health Council. These interviews revealed a consensus around the importance of cross-sector integration, such as that facilitated by the Pathways Community Hub model. These interviews contributed to the development of the concept of the Community Health Innovation Region in the model. In the absence of input on community development and investment strategies, additional interviews were conducted with the Kresge Foundation and the United Way during the design process. Project staff also reviewed and disseminated literature and webinars to advisory committee members on how best to realize the immense potential of public health to lower system-wide costs through prevention and patient

engagement, and reached out to content experts in systems change and community organizing. Additionally, the Michigan Association for Local Public Health, provided input and support into the role of public health within the Michigan's Health Innovation Plan.

The critical need for sustainable financing for public health services was brought up on several occasions by the State Innovation Model advisory committee, as was the need for a more meaningful link between public health, as a locus of population-level data and prevention efforts, and the health care delivery system. There was a strong consensus that the status quo of short-lived, grant-based programs or demonstrations does not create an environment that fosters improvement over time, or true innovation.

Options discussed for financing the delivery of public health services and community prevention strategies included expanding billing for services by local public health departments, and creating a comprehensive payment system to allow Patient Centered Medical Homes to better foster prevention among their patients. Furthermore, the potential for implementing new strategies and tools in public health programming was discussed within the advisory committee and in outreach meetings as a way to address a perceived lack of depth and impact in 'traditional' public health interventions. Ultimately, the group did not reach consensus on these specific mechanisms, but did agree that funding for population health strategies must be sustainable for a system that pays for health outcomes to be successful.

Topic I	*Review and identify options for leveraging community stabilization development initiatives in low income communities and encouraging community investment to improve community health;*
Deliberations	The advisory committee placed a unique emphasis on the importance of a community-integrated health system and a cross-sector approach at the local level that encourages and supports the significant role that communities must play in promoting health and preventing disease. This emphasis on community integration was embraced by the management team and incorporated into the model design in the Community Health Innovation Region. This element of the model includes a "health-in-all-policies" approach that aligns local stakeholders to address broad determinants of health and includes cross-sector partnerships that leverage community development and community investment. Further, this emphasis on a community-integrated health system is aligned with Governor Snyder's vision for Michiganders to be healthy, productive individuals, living in communities that support health and wellness.

The Linkages and Cross-Sector Partnerships focus group held in June and targeted interviews to address community development and investment in low income communities brought into focus the importance of cross-sector partnerships between medicine, public health, and community partners to address broad determinants of health. Stakeholders from philanthropy, health systems, and the community development sector were engaged, including the Kresge Foundation and the United Way Foundation. It is clear from the input received through the advisory committee, |

focus groups, and interviews that stakeholders believe that communities can and should link community development investments and health improvement strategies for better outcomes (e.g., through a healthy built environment). They also noted that aligning community development dollars with health priorities could provide funding streams for health improvement activities.

The following options for leveraging community stabilization development initiatives were considered:

- Leveraging and aligning health system Internal Revenue Service-required community benefit efforts in nonprofit hospitals with (Community Reinvestment Act-required) community development investments
- Pooling federal, state and local community development funds with community benefit dollars for sustainable financing for a collective investment in population health
- Taking a health-in-all-policies approach, convening community development and health improvement stakeholders for investments in healthy environments

Topic J	*Review and identify options for integrating early childhood and adolescent health prevention strategies with the primary and secondary educational system to improve student health, increase early intervention, and align delivery system performance with improved child health status;*
Deliberations	The importance of integrating early childhood and adolescent health prevention strategies with the primary and secondary education system to improve student health, increase early intervention, and align delivery system performance was raised several times over the course of the model design process. The head of the Division of Family and Community Health was an active member of the management team and provided many ideas to foster integration and focus on childhood development.
	The focus groups held in June provided an opportunity for stakeholders to present information about current cross-sector initiatives within Michigan designed to improve student health and academic outcomes. Focus group attendees were also asked to describe barriers that stand in the way of successful implementation of the initiatives and how those initiatives could be improved. Participants included stakeholders from the Michigan Department of Community Health, Washtenaw Health Initiative, School Community Health Alliance of Michigan, Greater Detroit Area Health Council, Michigan Association of Local Public Health, the Community Mental Health Authority of Clinton, Eaton and Ingham Counties, Michigan Chapter American Academy of Pediatrics, the Practice Transformation Institute, Michigan Primary Care Association, Mott Children's Health Center, and the West Michigan Community Mental Health System.
	Participants in each of the five State Innovation Model public outreach meetings convened across the state also described the need to integrate health prevention strategies into the education system. Multiple representatives from the School Community Health Alliance of Michigan provided feedback following these events through the online forum and via email. An advisory committee member from Mott

Children's Health Center was very helpful in describing possible approaches to integration and the success of initiatives tested in Michigan.

Stakeholders agreed that the foundations of prevention and wellness should begin during childhood and adolescence to enhance lifetime health outcomes and reduce health care costs. There was recognition that collaboration between cross-sector partners is the foundation to achieving these goals. Multiple initiatives and projects are taking place throughout Michigan, but are generally limited to specific geographic regions and are often limited by funding constraints and the burden of sustainability. The State Innovation Model should review and build upon successful initiatives and other ongoing projects, as data is emerging that demonstrates their impact on improving student health and reducing cost.

Stakeholder-identified current initiatives and projects:
- Child and Adolescent Health Centers
- Great Start Collaboratives
- Children's Healthcare Access Program
- Health Department of Northwest Michigan Early Childhood Behavior Health Initiative
- Matrix Human Services Transition to Success model
- Community Mental Health Authority of Clinton, Eaton and Ingham Counties behavior therapist integration
- Department of Human Services - Pathways to Potential program

Barriers:
- Multiple challenges to creating linkages among providers of child and adolescent services including different entry points into the system, lack of a common technology platform, and the absence of care coordination across government, health care, human services and education
- Grant and fragmented funding inhibits growth and sustainability of integrated and innovative health and school-based services

Consensus:
- The Patient Centered Medical Home baseline definition and designation process needs to allow for alternative provider configurations, such as a Patient Centered Medical Home within a school-based center
- Requirements for Accountable Systems of Care should include experience in networking with community providers, including schools
- Build upon current initiatives
- Capacity should be built not only for primary care, but also for behavioral health and oral health services

Topic K	*Review and identify options for creating models that integrate behavioral health, substance abuse, children's dental health, and long term services and support as part of multi-payer delivery system model and payment strategies;*
Deliberations	Representatives from behavioral health and long term services and supports were included on the advisory committee and management team, as well as in multiple focus

groups, work groups, public outreach meetings, and targeted interviews.

The Systems of Care focus group was organized to allow stakeholders to discuss current care coordination initiatives in Michigan. Stakeholders were also asked to discuss barriers and opportunities for alignment around their initiatives. The following initiatives were discussed in detail.

The Community Mental Health Authority of Clinton, Eaton, and Ingham counties has worked in a number of ways to form partnerships and linkages to support people in need of behavioral health services, including co-locating therapists and psychiatrists in primary care settings for adults and children, locating a Federally Qualified Health Center in their building, and hiring a nurse care manager to help link clients to services.

The Health Department of Northwest Michigan is involved in an early childhood behavioral health initiative designed by parents of children with social or emotional problems.

Michigan Center for Clinical Systems Improvement is a multi-stakeholder organization that facilitates the development of advanced clinical models in west Michigan and has structured projects around the integration of behavioral health and medical health using an evidence-based program developed at the University of Washington. The Michigan Center for Clinical Systems Improvement is building linkages to social services by making community outreach a key part of its projects.

The Community Mental Health system is exploring the development of safety net and specialty-service accountable care organizations particular to adults with severe and persistent mental illness and developmental disabilities. The specifications desired by the advisory committee for system-wide linkages are closely aligned with the current Community Mental Health service delivery model for the population it serves.

In southwest Michigan, health plans and prepaid inpatient health plans are sharing patient information through their Information Technology systems to allow each entity to assess patients' medical and mental health needs and see which services have been delivered to the patients.

In addition, the Care Coordination Work Group included stakeholders from many sectors including behavioral health, substance abuse, and long-term supports and services. The group strongly recommended that care coordination services should be integrated for all services that a person might need, including: long-term care, end-of-life care, advanced care planning, behavioral health, physical health, and social supports. The group also proposed that care coordination services should be reimbursed and shared care plans should be developed with clearly defined roles in order to avoid duplication of services, and suggested that these care coordination services should focus on high risk, high cost patients with complex needs, and that triggers should be

developed to ensure that these patients are identified and receive services that will support positive health outcomes. The work group agreed that the community mental health system and prepaid inpatient health plans in Michigan are fairly effectively addressing the needs of people with severe and persistent mental illness, but limited resources exist for people with mild to moderate mental illness. It was noted that there is a lack of available funding, and health plans have not been required to offer coverage for this population.

Representatives from Federally Qualified Health Centers were able to provide input concerning integrating substance abuse and dental health into the model. Many of these centers provide a wide range of services that include primary care, behavioral health, substance abuse counseling and treatment, and dental services.

Topic L	*Review and identify options for creating or expanding models such as the Administration on Community Living's Aging and Disability Resource Centers and Center for Medicare and Medicaid Services' Money Follows the Person Program and Balancing Incentives Payment Program to strengthen long-term services and support systems in a manner that promotes better health, reduces institutionalization, and helps older adults and people with disabilities maintain independence and maximize self-determination;*
Deliberations	Multiple representatives from long-term care and the aging services community participated in both the advisory committee and management team and took part in the ongoing discussions around care coordination. The Michigan Patient Centered Medical Home model strengthens the primary care infrastructure and assures that patients get the right care, by the right provider, at the right time, and in the right place, which will in turn strengthen both services to the aging and long term care services. Providing older adults with the added support of an ongoing relationship with a care team – which will be responsible for coordinating comprehensive care across the health system and for providing complex care management to those individuals who benefit from intensive care services – will improve the care that they receive. These care management services include: home care teams, planned visits to optimize chronic condition management, self-management support, advance directives, link to community resources, and others. Additionally, Michigan's Health Innovation Plan anticipates using global payment for the management of specific high cost and complex conditions. Global payments can cover the primary care, specialty care, diagnostic tests, and hospital and sub-acute services specific to the treatment of the condition. They show promise in addressing the needs of the aging community and promoting independence, as well as reducing the rate of increase in costs for the aging population by allowing for: • Integration of home and community-based resources and services • Eliminating unwanted, avoidable, or unnecessary acute care and specialty service utilization and cost
Topic M	*Review and identify options for using other policy levers that can support delivery system transformation.*

Deliberations	As mentioned previously, the Health Innovation Plan calls for the Department of Community Health to coordinate the many state policy levers that will drive participation as well as the infrastructure investments to support it, and provide overall accountability for implementation and evaluation. Alignment across state government aids effective and efficient program quality improvement and all of these initiatives will continue to be watched.

As mentioned previously, the Health Innovation Plan calls for the Department of Community Health to coordinate the many state policy levers that will drive participation as well as the infrastructure investments to support it, and provide overall accountability for implementation and evaluation. Alignment across state government aids effective and efficient program quality improvement and all of these initiatives will continue to be watched.

Additionally, State Innovation Model project staff will need to continue to engage the Department of Insurance and Financial Services to discuss possible regulatory and policy levers that might support multi-payer collaboration and participation.

Current issues being tracked for future deliberation include the work of both the Michigan Diversion Council and the Michigan Mental Health Commission, as they look for new ways to help integrate behavioral health information with physical health information

Other legal issues and possible policy levers being monitored:

The Sherman Act §1 and §2 (§1 prohibits contracts, combinations and conspiracies which unreasonable restrain competition and §2 prohibits monopolization, attempted monopolization and conspiracies to monopolize)

Clayton Act §18 and §7A (§18 prohibits mergers and acquisitions which may lessen competition or tend to create a monopoly and §7A which is also called the "Hart-Scott-Rodino Antitrust Improvements Act of 1976" requires parties to certain types of mergers, acquisitions , joint ventures and non-corporate formations to notify the Department of Justice and Federal Trade Commission about the transaction prior to completion)

The State should consider proposing legislation in the form of a State Action Doctrine, which would actively supervise any State Innovation Plan multi-payer/multi-provider initiative. Such a state regulatory scheme could preempt federal anti-trust laws. Enacting State Action Doctrine legislation would allow State Innovation Model participants, to form Accountable Systems of Care in furtherance of the Michigan's regulatory goals, therefore preempting federal anti-trust laws.

Stark (federal and state versions) specifically applies to patient referrals (referral prohibition and billing prohibition) that are unduly influenced by profit motive (applies to Medicare only)

Anti-Kickback (federal and state versions) prevents individuals from "knowingly and willingly" giving any payment to an individual to get someone to use health care services, where payment for those services is made under a federal health care program. (There are a large number of statutory exceptions and regulatory safe harbors, as this law is clearly exceedingly broad, that we will need to define.)

Civil Monetary Penalties apply when a hospital "knowingly makes a payment directly or indirectly to a physician as an inducement to reduce or limit services provided with respect to individuals" who are Medicaid or Medicare recipients and are under the direct care of the physician.

Insurance Laws may impart additional risk on Accountable Systems of Care that may meet the definition of" insurance risk", and may become subject to insurance regulation at the state level.

Professional Liability and Common Law issues revolve around the "standard of care". Generally, in order to go forward with a malpractice claim, the plaintiff must show that the harm arose from a departure from the standard of care. Accountable Systems of Care aggregation of data, along with other issues may change the standard of care and participants in the Accountable System of Care should be made aware (education and training) and the Accountable System of Care should probably examine means to mitigate any additional risk as much as possible.

Proposed/Pending Legislation:
Senate Bill 333 would require that the Michigan Department of Community Health establish and administer a Michigan Health Care Transparency database to collect and compile data from Michigan health insurers on the cost of health care services in Michigan. This type of database is often referred to as an "all-payer claims database", and will align with national, regional, and other uniform all-payer claims database standards.

Senate Bill 568 would repeal Parts 170 (Medicine) and 175 (Osteopathic Medicine and Surgery) of the Public Health Code, which regulate physicians and physician assistants and would create Part 171 Patient Care of the Code to regulate allopathic and osteopathic physicians, physician assistants, and advanced practice registered nurses (who currently are regulated as nurses under Part 172)and would, in part:
- Replace the regulatory boards and disciplinary subcommittees under Parts 170 and 175 with separate task forces for allopathic physicians, osteopathic physicians, physician assistants, and advanced practice registered nurses under proposed Part 171
- Allow health professional licensees to form a patient care team and require a team to have a practice agreement
- Create the Michigan Patient Care Board and require it to establish a model practice agreement for patient care teams and evaluate the model every two years
- Require physician assistants and advanced practice registered nurses to be part of a care team member in order to practice
- Extend to advanced practice registered nurses certain provisions that apply to physician assistants
- Include physician assistants and an advanced practice registered nurses in the definition of "prescriber" in Part 177 (Pharmacy Practice and Drug Control).
- If a licensee organized as a professional corporation or a professional limited

	liability company with other licensees, require each shareholder of the corporation or member of the company to comply with all applicable requirements of Article 15 (Occupations) to engage in his or her health profession Senate Bills 569 and 570 would amend the Business Corporation Act and the Michigan Limited Liability Company Act, respectively, to: • Allow physician assistants to form professional corporations with only physician assistants as shareholders • Include the services of advanced practice registered nurses and nurse anesthetists in the definition of "professional service" • Authorize a licensed physician to form a professional corporation or professional limited liability company with any other individuals who were licensed under the Public Health Code, rather than licensed physician assistants • Allow a licensed physician to form a professional limited liability company with one or more nurses with specialty certifications in the field of nurse anesthetist
Topic N	*Review and identify options for leveraging health information technology, electronic health records, and health information exchange technologies, including interoperable technologies, to improve health and coordination of care across service providers (including post-acute and long-term care providers) and targeted beneficiaries. Specific plans should be to support testing of the Recipient's multi-payer model of delivery and payment reform.*
Deliberations	Michigan has a large community of highly committed stakeholders working on health information technology and health information exchange. They form an innovation sub-community on their own, with regular meetings of stakeholders working on use cases, governance issues, privacy and security on Michigan's data exchange, patient consent, and clinical quality data architecture. The Department of Community Health includes an Office of Health Information Technology which reports to the Director of the Department, but also to the Health Information Technology Commission created by the legislature in May 2006 to facilitate and promote the design, implementation, operation, and maintenance of an interoperable health care information infrastructure in Michigan. Due to the electronic health record incentive program and Michigan's Office of National Coordinators of Health Information Technology-funded Health Information Exchange activities, many stakeholders were already aware of many issues and advantages to health information exchange, and it was considered foundational to most discussions about innovation, model design, delivery system transformation, and payment model innovation. Michigan's Health Information Technology coordinator is on the management team and led a work group examining the technology infrastructure needs of the State Innovation Model. Stakeholders included: Michigan Department of Community Health Office of Medicaid Health Information Technology, Michigan Health Information Network Shared Services, University of Michigan - Michigan Data Collaborative, University of Michigan School of Health Informatics, Michigan Center for Effective IT Adoption (the regional extension center), Southeast Michigan Beacon Community,

Michigan Health & Hospital Association, Michigan Department of Education – Office of Great Start, Michigan Consumers for Healthcare, Michigan Department of Technology, Management & Budget, Michigan State Medical Society, and health systems.

The purpose of the Health Information Technology-Health Information Exchange Work Group was to determine how technology supports, enables and provides the foundation for the State Innovation Model, and what data and infrastructure are needed to strengthen primary care infrastructure, support coordinated care for individuals with intensive support needs, improve systems of care to ensure appropriate utilization of health care services, build capacity within communities to improve population health, and reduce administrative complexity. This group met three times in person, and stakeholders shared ideas for innovative approaches to enhance health information technology and health information exchange in order to improve health and coordination of care across providers and health care consumers.

The group discussed the underlying technical and governance infrastructure needs to support a community integrated health system. Work group members were initially asked to describe existing health information technology-health information exchange infrastructure and the to-be initiatives needed to support the functional elements of the community-integrated system. Members also described gaps between the current landscape and the desired functionality. Lack of universal standards surfaced as a key barrier to achieving meaningful information exchange in a timely fashion.

Patient portals were discussed, as Meaningful Use Stage 2 requirements will make these a much more common part of the landscape. The work group agreed on a need for portals to be aligned and standardized, so that consumers would not have to log in to multiple systems. The work group also considered whether patient portals needed to communicate with each other, and if so, what data needed to be exchanged. Furthermore, it was pointed out that the question of information flow from patient portals into electronic health records and vice-versa was likely to require more discussion and development.

Members of the work group also believe that identity management and the creation of a trusted patient registry that is accurate and secure are critical components to patient engagement and self-management support. There is too much variation in the standards for health information exchange, and the recent flood of health information standards need to be balanced with interoperability opportunities. Advancing electronic health record and information technology systems that are interoperable and/or capable of exchanging electronic health information between network and out-of-network providers and services is difficult with the lack of uniformity and standardization.

Many electronic health records are highly customized, and often times, that customization means that they are proprietary and cannot be shared. In addition, having

highly customized information becomes very difficult as providers find it challenging to respond to the variety of initiatives that are underway due to limited resources, making health information technology-health information exchange a lower priority. Providers need good guidance from a reliable source in order to allow them to make effective choices when selecting an electronic health record system or health information exchange, as there are a large quantity of vendors and systems. Other guidance could include: what specifications will meet the provider's needs (without customizing to inoperability), education on the electronic health record market to inform their selection of a vendor, and assistance with what they need to include in vendor contracts.

The work group identified three primary needs from the health information technology-health information exchange landscape: (1) facilitating the appropriate exchange of data, (2) enabling the coordination of individual care plans, and (3) supporting a person-centered approach.

The work group determined that Michigan can leverage current and planned health information exchange infrastructure and related initiatives to achieve the State Innovation Model goals. Specifically, the work group identified the following health information exchange categories as key elements in a transformed health system:

- Results Delivery: Activities that enable the ordering and delivery of diagnostics tests and associated results
- Public Health: The capture and distribution of information supporting the activities related to public health
- Care Coordination & Patient Safety: Communication collaboration among multiple entities to follow best practices to obtain maximized health outcomes.
- Quality & Administrative: The activities related to payment and operations and quality or performance reporting
- Patient engagement: The activities related to informing, engaging, empowering, and partnering with consumers in their health
- Infrastructure: The common technical, legal, policy, financial, and process functions necessary to support other elements

The work group agreed that the following guiding principles most effectively leverage the current Michigan health information technology-health information exchange infrastructure while setting the foundation for successful and meaningful data exchange under the State Innovation Model.

- The Michigan approach to Data Exchange is the backbone for health information exchange under the State Innovation Model
- Standards are based on the Office of National Coordinators of Health Information Technology 2014 Meaningful Use Electronic Health Record standards and Center for Medicare and Medicare Services Stage 2 Meaningful Use Core and Menu Objectives
- The State Innovation Model encourages vendors to work with health information technology-health information exchange stakeholders to reduce burdens to the adoption of health information technology.

- The State Innovation Model supports public-private partnerships to develop statewide policy and governance standards
- The State Innovation Model encourages collaboration and coordination amongst commissions, state-supported work groups, councils, and other identified stakeholder groups to bring folds together and eliminate silos
- Consumer input and engagement on the use of health information technology and health information exchange is a central part of the State Innovation Model

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[1] Health Affairs, Health Policy brief, "GME Policy", 10-16-12)

Appendix 4

Appendix 4.1: Rapid Cycle and Improvement Process

Source: Langley *et al.* (1996)